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ABSTRACT

This introductory packet provides an introduction to affect and mood problems, framing the discussion within the classification scheme developed by the American Pediatric Association. Included is information on the symptoms and severity of a variety of affect and mood problems, as well as information on interventions ranging from environmental accommodations to behavior management to medication. The packet is divided into six sections. Section 1 highlights the classification of affect and mood problems. Sections 2 and 3 provide a discussion of the broad continuum of anxiety problems and a quick overview of some basic resources. Section 4 presents interventions for affect and mood problems, including accommodations to reduce problems, behavior management, and medication. Section 5 presents additional resource aids on depression, bipolar disorder, and suicide. Section 6 contains a discussion on keeping affect and mood problems in broad perspective. The packet concludes with a brief list for further reading, as well as a list of agencies that can provide additional information. (GCP)

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An Introductory packet on

Affect and Mood Problems
Related to School Aged Youth

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Under the auspices of the School Mental Health Project in the Department of Psychology at UCLA, our center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

MISSION: *To improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools.*

Through collaboration, the center will

- enhance practitioner roles, functions and competence
- interface with systemic reform movements to strengthen mental health in schools
- assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools

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About the Center's Clearinghouse

The scope of the Center's Clearinghouse reflects the School Mental Health Project's mission -- to enhance the ability of schools and their surrounding communities to address mental health and psychosocial barriers to student learning and promote healthy development. Those of you working so hard to address these concerns need ready access to resource materials. The Center's Clearinghouse is your link to specialized resources, materials, and information. The staff supplements, compiles, and disseminates resources on topics fundamental to our mission. As we identify what is available across the country, we are building systems to connect you with a wide variety of resources. Whether your focus is on an individual, a family, a classroom, a school, or a school system, we intend to be of service to you. Our evolving catalogue is available on request; and available for searching from our website.

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We can provide or direct you to a variety of resources, materials, and information that we have categorized under three areas of concern:

- Specific psychosocial problems
- Programs and processes
- System and policy concerns

Among the various ways we package resources are our *Introductory Packets, Resource Aid Packets, special reports, guidebooks*, and *continuing education units*. These encompass overview discussions of major topics, descriptions of model programs, references to publications, access information to other relevant centers, organizations, advocacy groups, and Internet links, and specific tools that can guide and assist with training activity and student/family interventions (such as outlines, checklists, instruments, and other resources that can be copied and used as information handouts and aids for practice).

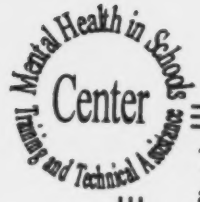
Accessing the Clearinghouse

- E-mail us at **smhp@ucla.edu**
- FAX us at (310) 206-8716
- Phone (310) 825-3634
- Write School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, Los Angeles, CA 90095-1563

Check out recent additions to the Clearinghouse on our Web site: **http://smhp.psych.ucla.edu**

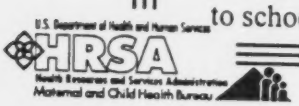
All materials from the Center's Clearinghouse are available for order for a minimal fee to cover the cost of copying, handling, and postage. Most materials are available for free downloading from our website.

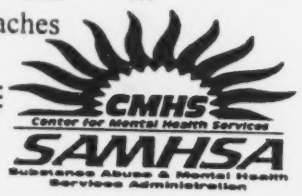
If you know of something we should have in the clearinghouse, let us know.



The *Center for Mental Health in Schools* operates under the auspices of the School Mental Health Project at UCLA.* It is one of two *national centers* concerned with mental health in schools that are funded in part by the U.S. Department of Health and Human Services, Office of Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration -- with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (Project #U93 MC 00175).

The UCLA Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. In particular, it focuses on comprehensive, multifaceted models and practices to deal with the many external and internal barriers that interfere with development, learning, and teaching. Specific attention is given policies and strategies that can counter marginalization and fragmentation of essential interventions and enhance collaboration between school and community programs. In this respect, a major emphasis is on enhancing the interface between efforts to address barriers to learning and prevailing approaches to school and community reforms.





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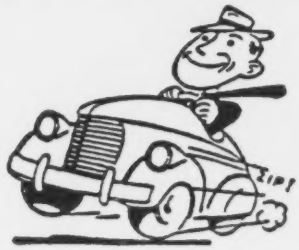

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Overview

In providing an introduction to affect and mood problems, a discussion framed within the classification scheme developed by the American Pediatric Association is offered. Included is information on the symptoms and severity of a variety of affect and mood problems, as well as information on interventions -- ranging from environmental accommodations to behavior management to medication. The section concludes with a brief list for further reading, as well as a list of agencies that can provide additional information.

Affect and Mood Problems

This introductory packet contains:

Overview

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- A. Labeling Troubled & Troubling Youth 1
- B. Environmental Situations & Potentially Stressful Events 1
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I. Keeping The Environment in Perspective as a Cause of Commonly Identified Psychosocial Problems.

A large number of students are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters have trouble behaving in classrooms; only a small percent have attention deficit or a conduct disorder. In some schools, large numbers of students have problems learning; only a few have learning disabilities. Individuals suffering from true internal pathology represent a relatively small segment of the population. A caring society tries to provide the best services for such individuals; doing so includes taking great care not to misdiagnose others whose "symptoms" may be similar, but are caused by factors other than internal pathology. Such misdiagnoses lead to policies and practices that exhaust available resources in ineffective ways. A better understanding of how the environment might cause problems and how focusing on changing the environment might prevent problems is essential.

A. Labeling Troubled and Troubling Youth: The Name Game

She's depressed.

That kid's got an attention deficit hyperactivity disorder.

He's learning disabled.

What's in a name? Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as ADHD, depression, and LD. This happens despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

Diagnosing Behavioral, Emotional, and Learning Problems

The thinking of those who study behavioral, emotional, and learning problems has long been dominated by models stressing *person* pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems.

Many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment. To counter nature *versus* nurture biases in thinking about problems, it helps to approach all diagnosis guided by a broad perspective of what determines human behavior.

A Broad View of Human Functioning

Before the 1920's, dominant thinking saw human behavior as determined primarily by person variables, especially inborn characteristics. As behaviorism gained in influence, a strong competing view arose. Behavior was seen as shaped by environmental influences, particularly the stimuli and reinforcers one encounters.

Today, human functioning is viewed in *transactional* terms -- as the product of a reciprocal interplay between person and environment (Bandura, 1978). However, prevailing approaches to labeling and addressing human problems still create the impression that problems are determined by *either* person or environment variables. This is both unfortunate and unnecessary -- unfortunate because such a view limits progress with respect to research and practice, unnecessary because a transactional view encompasses the position that problems may be caused by person, environment, or both. This broad paradigm encourages a comprehensive perspective of cause and correction.

Toward a Broad Framework

A broad framework offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid over-diagnosing internal pathology. Such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum (referred to as Type I problems). At the other end are problems caused primarily by pathology within the person (Type III problems). In the middle are problems stemming from a relatively equal contribution of environmental and person sources (Type II problems).

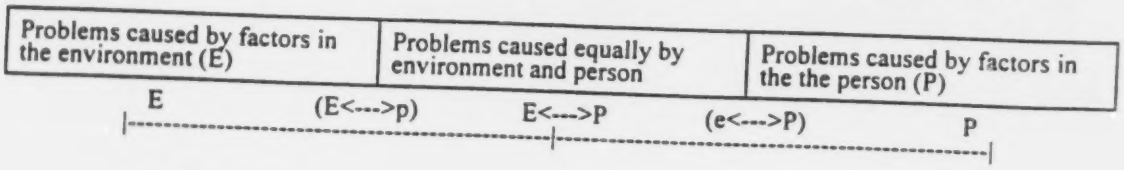
Diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause



Type I problems	Type II problems	Type III problems
•caused primarily by environments and systems that are deficient and/or hostile	•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)	•caused primarily by person factors of a pathological nature
•problems are mild to moderately severe and narrow to moderately pervasive	•problems are mild to moderately severe andpervasive	•problems are moderate to profoundly severe and moderate to broadly pervasive

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971). It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them. "To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community.

Nicholas Hobbs

After the general groupings are identified, it becomes relevant to consider the value of differentiating subgroups or subtypes within each major type of problem. For example, subtypes for the Type III category might first differentiate behavioral, emotional, or learning problems arising from serious internal pathology (e.g., structural and functional malfunctioning within the person that causes disorders and disabilities and disrupts development). Then subtypes might be differentiated within each of these categories. For illustrative purposes: Figure 2 presents some ideas for subgrouping Type I and III problems.

References

Bandura, A. (1978). The self system in reciprocal determination. *American Psychologist, 33*, 344-358.

Ryan, W. (1971). *Blaming the victim.* New York: Random House.

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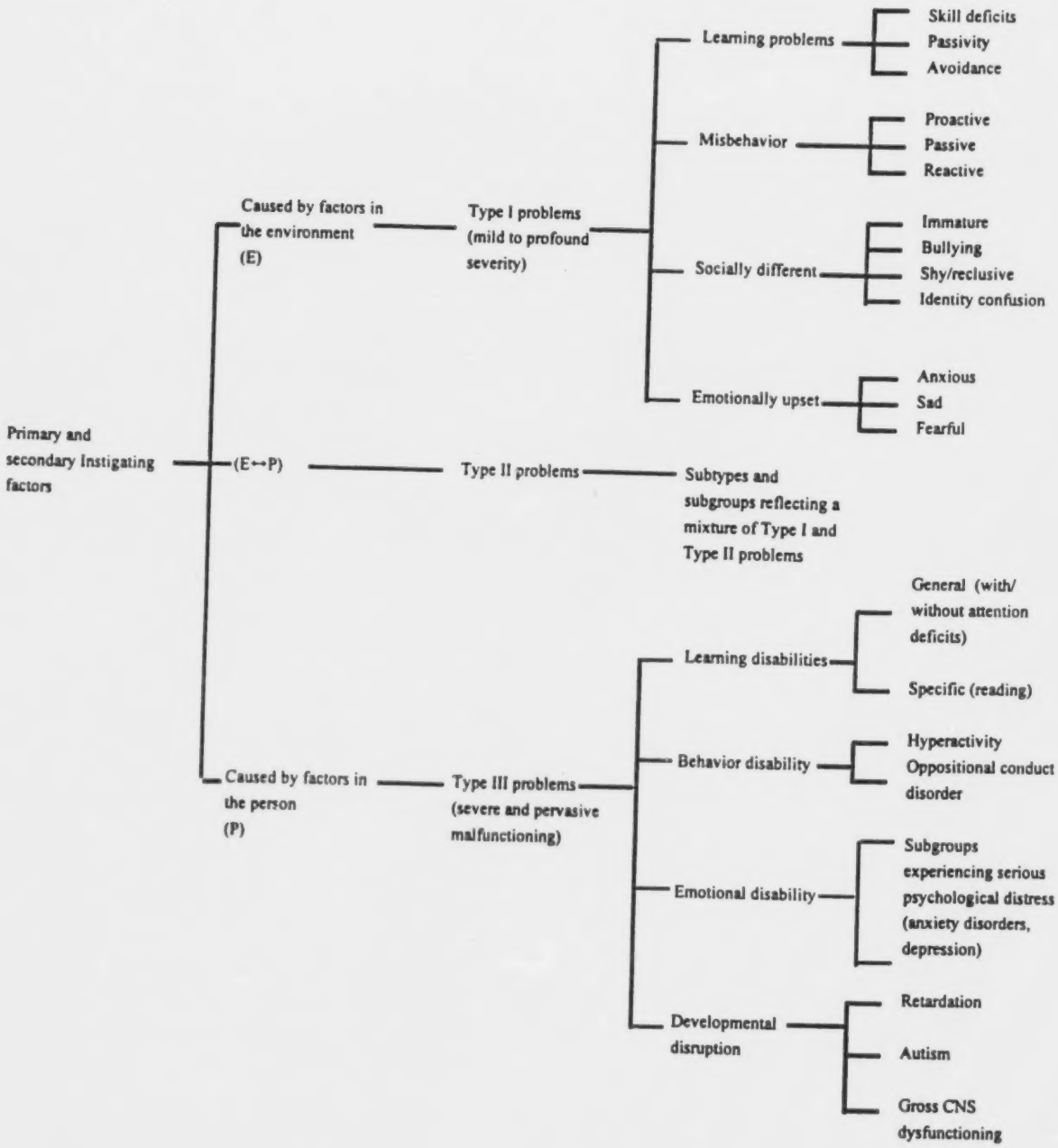
Figure 2: Categorization of Type I, II, and III Problems



Source: H. S. Adelman and L. Taylor (1993). Learning problems and learning disabilities. Pacific Grove. Brooks/Cole. Reprinted with permission.

B. Environmental Situations and Potentially Stressful Events

The American Academy of Pediatrics has prepared a guide on mental health for primary care providers. The guide suggests that commonly occurring stressful events in a youngsters life can lead to common behavioral responses. Below are portions of Tables that give an overview of such events and responses.

Environmental Situations and Potentially Stressful Events Checklist

Challenges to Primary Support Group
- Challenges to Attachment Relationship
- Death of a Parent or Other Family Member
- Marital Discord
- Divorce
- Domestic Violence
- Other Family Relationship Problems
- Parent-Child Separation

Changes in Caregiving
- Foster Care/Adoption/Institutional Care
- Substance-Abusing Parents
- Physical Abuse
- Sexual Abuse
- Quality of Nurture Problem
- Neglect
- Mental Disorder of Parent
- Physical Illness of Parent
- Physical Illness of Sibling
- Mental or Behavioral disorder of Sibling

Other Functional Change in Family
- Addition of Sibling
- Change in Parental Caregiver

Community of Social Challenges
- Acculturation
- Social Discrimination and/or Family Isolation

Educational Challenges
- Illiteracy of Parent
- Inadequate School Facilities
- Discord with Peers/Teachers

Parent or Adolescent Occupational Challenges
- Unemployment
- Loss of Job
- Adverse Effect of Work Environment

Housing Challenges
- Homelessness
- Inadequate Housing
- Unsafe Neighborhood
- Dislocation

Economic Challenges
- Poverty
- Inadequate Financial Status

Legal System or Crime Problems

Other Environmental Situations
- Natural Disaster
- Witness of Violence

Health-Related Situations
- Chronic Health Conditions
- Acute Health Conditions

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics.

Common Behavioral Responses to Environmental Situations and Potentially Stressful Events

INFANCY-TODDLERHOOD (0-2Y)
BEHAVIORAL MANIFESTATIONS

- **Illness-Related Behaviors**
  - N/A
- **Emotions and Moods**
  - Change in crying
  - Change in mood
  - Sullen, withdrawn
- **Impulsive/Hyperactive or Inattentive Behaviors**
  - Increased activity
- **Negative/Antisocial Behaviors**
  - Aversive behaviors, i.e., temper tantrum, angry outburst
- **Feeding, Eating, Elimination Behaviors**
  - Change in eating
  - Self-induced vomiting
  - Nonspecific diarrhea, vomiting
- **Somatic and Sleep Behaviors**
  - Change in sleep
- **Developmental Competency**
  - Regression or delay in developmental attainments
  - Inability to engage in or sustain play
- **Sexual Behaviors**
  - Arousal behaviors
- **Relationship Behaviors**
  - Extreme distress with separation
  - Absence of distress with separation
  - Indiscriminate social interactions
  - Excessive clinging
  - Gaze avoidance, hypervigilant gaze...

MIDDLE CHILDHOOD (6-12Y)
BEHAVIORAL MANIFESTATIONS

- **Illness-Related Behaviors**
  - Transient physical complaints
- **Emotions and Moods**
  - Sadness
  - Anxiety
  - Changes in mood
  - Preoccupation with stressful situations
  - Self -destructive
  - Fear of specific situations
  - Decreased self-esteem
- **Impulsive/Hyperactive or Inattentive Behaviors**
  - Inattention
  - High activity level
  - Impulsivity
- **Negative/Antisocial Behaviors**
  - Aggression
  - Noncompliant
  - Negativistic
- **Feeding, Eating, Elimination Behaviors**
  - Change in eating
  - Transient enuresis, encopresis
- **Somatic and Sleep Behaviors**
  - Change in sleep
- **Developmental Competency**
  - Decrease in academic performance
- **Sexual Behaviors**
  - Preoccupation with sexual issues
- **Relationship Behaviors**
  - Change in school activities
  - Change in social interaction such as withdrawal
  - Separation fear
  - Fear of being alone
- **Substance Use/Abuse...**

EARLY CHILDHOOD (3-5Y)
BEHAVIORAL MANIFESTATIONS

- **Illness-Related Behaviors**
  - N/A
- **Emotions and Moods**
  - Generally sad
  - Self-destructive behaviors
- **Impulsive/Hyperactive or Inattentive Behaviors**
  - Inattention
  - High activity level
- **Negative/Antisocial Behaviors**
  - Tantrums
  - Negativism
  - Aggression
  - Uncontrolled, noncompliant
- **Feeding, Eating, Elimination Behaviors**
  - Change in eating
  - Fecal soiling
  - Bedwetting
- **Somatic and Sleep Behaviors**
  - Change in sleep
- **Developmental Competency**
  - Regression or delay in developmental attainments
- **Sexual Behaviors**
  - Preoccupation with sexual issues
- **Relationship Behaviors**
  - Ambivalence toward independence
  - Socially withdrawn, isolated
  - Excessive clinging
  - Separation fears
  - Fear of being alone

ADOLESCENCE (13-21Y)
BEHAVIORAL MANIFESTATIONS

- **Illness-Related Behaviors**
  - Transient physical complaints
- **Emotions and Moods**
  - Sadness
  - Self-destructive
  - Anxiety
  - Preoccupation with stress
  - Decreased self-esteem
  - Change in mood
- **Impulsive/Hyperactive or Inattentive Behaviors**
  - Inattention
  - Impulsivity
  - High activity level
- **Negative/Antisocial Behaviors**
  - Aggression
  - Antisocial behavior
- **Feeding, Eating, Elimination Behaviors**
  - Change in appetite
  - Inadequate eating habits
- **Somatic and Sleep Behaviors**
  - Inadequate sleeping habits
  - Oversleeping
- **Developmental Competency**
  - Decrease in academic achievement
- **Sexual Behaviors**
  - Preoccupation with sexual issues
- **Relationship Behaviors**
  - Change in school activities
  - School absences
  - Change in social interaction such as withdrawal
- **Substance Use/Abuse...**

* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics

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Mood Disorders in Children and Adolescents

by Anne Brown

Adapted from an an article of the same name in the NARSAD Research Newsletter, Winter 1996.

Many researchers believe that mood disorders in children and adolescents represent one of the most under diagnosed group of illnesses in psychiatry. This is due to several factors:

(1)children are not always able to express how they feel,
(2) the symptoms of mood disorders take on different forms in children than in adults,
(3) mood disorders are often accompanied by other psychiatric disorders which can mask depressive symptoms, and
(4) many physicians tend to think of depression and bipolar disorder as illnesses of adulthood.

Not surprisingly, it was only in the 1980's that mood disorders in children were included in the category of diagnosed psychiatric illnesses.

How Prevalent are Mood Disorders in Children and Adolescents?

7-14% of children will experience an episode of major depression before the age of 15.
20-30% of adult bipolar patients report having their first episode before the age of 20.
Out of 100,000 adolescents, two to three thousand will have mood disorders out of which 8-10 will commit suicide.

Depression

There is emerging evidence that major depression can develop in prepubertal children and that it is a significant clinical occurrence among adolescents. Recent epidemiologic studies have shown that a large proportion of adults experience the onset of major depression during adolescence and early adulthood.

By studying high-risk populations for developing childhood mood disorders, researchers hope to learn more about the onset and course of depression. Myrna M. Weissman, Ph.D. of Columbia University (a NARSAD Established Investigator and 1994 Selo Prize Co-Winner) has found an increased prevalence of major depression as well as a variety of other psychiatric problems in the children of depressed parents compared with those of normal parents. Specifically, she has discovered that the onset of major depression was significantly earlier in both male and female children of depressed parents (mean age of 12.7 years) compared with those of normal parents (mean age, 16.8 years). She has also observed sex differences in rates of depression to begin in adolescence. Before 10 years of age, she found a low frequency and equal sex ratio, however by 16 years of age, there was a marked increase in major depression in girls, as compared to boys of the same age.

The essential features of mood disorders are the same in children as in adults, although children exhibit the symptoms differently. Unlike adults, children may not have the vocabulary to accurately describe how they feel and, therefore may express their problems through behavior. The following behaviors may be associated with mood disorders in children:

- *In Preschool Children*:

Somber Appearance, almost ill-looking; they lack the bounce of their nondepressed peers. They may be tearful or spontaneously irritable, not just upset when they do not get their way. They make frequent negative self-statements and are often self-destructive.

- *In Elementary School-Aged Children and Adolescence*:

Disruptive behavior, possible academic difficulties, and

peer problems. Increased irritability and aggression, suicidal threats, and worsening school performance. Parents often say that nothing pleases the children, that they hate themselves and everything around them.

Bipolar Disorder

There has been a great deal of diagnostic uncertainty surrounding bipolar disorder in children. This may be caused by a major difference in the way mania is expressed in bipolar children versus adults. A look back at the histories of adults with bipolar symptoms often shows that mood swings began around puberty, however there is a frequent 5-to-10 year lag between the onset of symptoms and display of the disorder serious enough to be recognized and require treatment, resulting in the under diagnosis of bipolar disorder.

Unlike adult bipolar patients, manic children are seldom characterized by euphoric mood. Rather, the most common mood disturbance in manic children may be better described as irritable, with "affective storms" or prolonged and aggressive temper outbursts. For example, a study by Gabrielle A. Carlson, M.D. of State University of New York-Stony Brook, found that bipolar children under the age of 9 had more irritability, crying, and motor agitation as compared to older bipolar children, who were more likely to have "classically manic symptoms" such as euphoria and grandiosity. In addition, it has been suggested that the course of childhood-onset bipolar disorder tends to be chronic and continuous rather than episodic and acute, as is the adult form of the disorder.

Other aspects that make diagnosing bipolar disorder in children difficult is the frequency with which bipolar disorder is mistaken for attention-deficit hyperactivity disorder (ADHD), conduct disorder (which includes symptoms of socially unacceptable, violent or criminal behavior), or schizophrenia.

Bipolar Disorder vs. Other Childhood Disorders

ADHD and bipolar disorder have many overlapping features which include: distractibility, inattention, impulsivity, and hyperactivity. However, bipolar disorder has several differentiating features, which include: psychosis, depression, aggression, excitability, rapid mood swings, inappropriate affect and disregard for feelings of others.

Conduct disorder overlaps with bipolar disorder on symptoms such as: impulsivity, shoplifting, substance abuse, difficulties with the law and aggressiveness . However, in bipolar disorder, some distinguishing factors include: antisocial behavior with elevated or irritable mood and lack of peer group influence.

When comparing schizophrenia and bipolar, their common symptoms include: grandiose and paranoid delusions and hallucinatory phenomena. However, in schizophrenia, differentiating features include: thought disorder and bizarre delusions.

The widely accepted belief that childhood-onset mania is rare has recently been challenged. Many researchers including Janet Wozniak, M.D. of Harvard Medical School (a NARSAD Young Investigator) have shown a major overlap in the symptoms of mania and ADHD. Dr. Wozniak believes that this overlap may be responsible for the under identification and misdiagnosis of bipolar disorder. In her study of clinically referred children, she found 16% to have mania with irritable and mixed moods (i.e. with symptoms of depression and mania occurring simultaneously). Also, she found that the children meeting the criteria for mania frequently also met the criteria for ADHD (the rate of ADHD in children with mania was 98%, while the rate of mania in children with ADHD was only 20%).

Schizophrenia has also been found to be mistaken for manic depression in adolescents. Despite the fact that psychotic features are a well-established part of adolescent manic-depressive illness, many clinicians continue to believe that thought disorder, grandiosity, and bizarre delusional and hallucinatory phenomena are distinctively characteristic of schizophrenia. Difficulties often arise in differentiating blunted from depressive affect and apathy from depression-induced delay in response time to questions.

Treatments

It is important for children suffering from mood disorders to receive prompt treatment because early onset places children at a greater risk for multiple episodes of depression throughout their life span. Children who experience their first episode of depression before the

age of 15 have a worse prognosis when compared with patients who had a later onset of the disorder.

At the present time, there is no definitive treatment for the spectrum of mood disorders in children, although some researchers believe that children respond well to treatment because they readily adapt and their symptoms are not yet entrenched. Treatment consists of a combination of interventions. Medications can be useful for cases of major depression or childhood onset mania, and psychotherapy can help children express their feelings and develop ways of coping with the illness. Some other helpful interventions that may be used are educational and family therapy.

Children suspected of mood disorders should be evaluated by a child psychiatrist, or if one is not available an adult psychiatrist who has experience in treating children. It is important that the clinician has had special training in speaking with children, utilizing play therapy, and can treat children in context of a family unit.

Suicide

An estimated 2,000 teenagers per year commit suicide in the United States, making it the leading cause of death after accidents and homicide. According to David Schaffer, M.D., of Columbia University (a NARSAD Established Investigator), suicidal behavior is uncommon before puberty, with the incidence of suicide attempts reaching its peak at around age 15 and becoming less common by the late teens. Studies of adolescent suicides in New York, Pittsburgh and Finland indicate that approximately 90 percent of the teenagers who commit suicide have a psychiatric diagnosis, most often a form of mood disorder and/or alcohol or substance abuse.

As in adults, suicide attempts occur more often in females (a ratio of 9 to 1), with overdose and wrist-cutting the most common means. Completed suicide occurs more often in males (a ratio of 3 to 1), usually white males, with shooting (62 percent) and hanging (19 percent) the most common means.

Biological Theories on Suicide

A number of biological theories are emerging to explain suicidal behavior. The available evidence points to hyposerotonergic functioning in studies of both completers and attempters. In suicide victims' brains, an increase in postsynaptic 5-hydroxytryptamine type 2 (5-HT2) receptors was found in the prefrontal cortex, suggesting that a compensatory increase in receptor density occurred in response to decreased serotonin release. The most robust findings in postmortem brains have been the measurements of low levels of serotonin (5-HT) and its major metabolite, 5-hydroxyindoleacetic acid (5-HIAA). Those findings were localized to the brainstem (the level of cell bodies) and were not found in the cortex. Completers have also shown alterations in noradrenergic (the activation of norepinephrine in the transmission of nerve impulses) but not cholinergic (of autonomic nerve fibers) pathways.

Several clinical studies have also found evidence of family histories of suicidal behavior, suggesting the likelihood of genetic factors playing a role in suicide. Twin studies provide evidence for genetic transmission of this vulnerability as twins share the same environment but differ in number of genes shared. Of 150 sets of twins reported in which at least one twin committed suicide, all 10 of the pairs in which both committed suicide were identical twins, and half of those were concordant for the same psychiatric illness.

Identifying the Vulnerable

Dr. Schaffer believes that screening out the vulnerable groups of children and adolescents for the risk factors of suicide and then referring them for treatment is the best way to lower the staggering teenage suicide rate. Students are regarded as high-risk if they have indicated suicidal ideation within the last three months, if they have ever made a prior suicide attempt, or if they indicate severe mood problems, excessive alcohol consumption or substance use.

In summary, mood disorders in children and adolescents are much more common than was originally estimated. This underestimation was primarily due to the diagnostic confusion surrounding overlapping symptoms from other childhood disorders and the difference in the expression of mania in children versus adults. Many research efforts are underway to better diagnose and identify the children and adolescents who are at risk for mood disorders. It is hoped that by identifying the most vulnerable individuals and providing them with treatment, we will finally start to see a decline in the staggering suicide rates for adolescents.

II. The Broad Continuum of Affect and Mood Problems

A. Developmental Variations
B. Problems
C. Disorders

1. Developmental Variations: Behaviors within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATION	COMMON DEVELOPMENTAL PRESENTATIONS
Sadness Variation Transient depressive responses or mood changes to stress are normal in otherwise healthy populations.	**Infancy** The infant shows brief expressions of sadness, which normally first appear in the last quarter of the first year of life, manifest by crying, brief withdrawal, and transient anger.
Bereavement Sadness related to a major loss that typically persists for less than 2 months after the loss. However, the presence of certain symptoms that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a major depressive disorder. These include guilt about things other than actions taken or not taken by the survivor at the time of death, thoughts of death, and morbid preoccupation with worthlessness.	**Early Childhood** The child may have transient withdrawal and sad affect that may occur over losses and usually experiences bereavement due to the death of a parent or the loss of a pet or treasured object. **Middle Childhood** The child feels transient loss of self-esteem over experiencing failure and feels sadness with losses as in early childhood. **Adolescence** The adolescent's developmental presentations are similar to those of middle childhood but may also include fleeting thoughts of death. Bereavement includes loss of a boyfriend or girlfriend, friend, or best friend.

SPECIAL INFORMATION

A normal process of bereavement occurs when a child experiences the death of or separation from someone (person or pet) loved by the child. There are normal age-specific responses as well as responses related to culture, temperament, the nature of the relationship between the child and the one the child is grieving, and the child's history of loss. While a child may manifest his or her grief response for a period of weeks to a couple of months, it is important to understand that the loss does not necessarily go away within that time frame. Most children will need to revisit the sadness at intervals (months or years) to continue to interpret the meaning of the loss to their life and to examine the usefulness of the coping mechanisms used to work through the sadness. A healthy mourning process requires that the child has a sense of reality about the death and access to incorporating this reality in an ongoing process of life. Unacknowledged, invalidated grief usually results in an unresolving process and leads to harmful behaviors toward self or others. Symptoms reflecting grief reaction may appear to be mild or transient, but care must be taken to observe subtle ways that unexpressed sadness may be exhibited.

Children in hospitals or institutions often experience some of the fears that accompany a death or separation. These fears may be demonstrated in actions that mimic normal grief responses.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics.

DEVELOPMENTAL VARIATION

Thoughts of Death Variation

Anxiety about death in early childhood.

Focus on death in middle childhood or adolescence.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Not relevant at this age.

Early Childhood
In early childhood anxiety about dying may be present

Middle Childhood
Anxiety about dying may occur in middle childhood, especially after a death in the family.

Adolescence
Some interest with death and morbid ideation may be manifest by a preference for black clothing and an interest in the occult. If this becomes increased to a point of preoccupation, a problem or a serious ideation should be considered.

DEVELOPMENTAL VARIATION

Thoughts of Death Problem

The child has thoughts of or a preoccupation with his or her own death.

If the child has thoughts of suicide, consider suicidal ideation and attempts (next page).

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Unable to assess

Early and Middle Childhood
The child may express a wish to die through discussion or play. This often follows significant punishment or disappointment.

Adolescence
The adolescent may express nonspecific ideation related to suicide.

SPECIAL INFORMATION

Between 12% and 25% of primary school and high school children have some form of suicidal ideation. Those with a specific plan or specific risk factors should be considered at most risk.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

2. Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

PROBLEM

Sadness Problem

Sadness or irritability that begins to include some symptoms of major depressive disorders in mild form.

- ☐ depressed/irritable mood
- ☐ diminished interest or pleasure
- ☐ weight loss/gain, or failure to make expected weight gains
- ☐ insomnia/hypersomnia
- ☐ psychomotor agitation/retardation
- ☐ fatigue or energy loss
- ☐ feelings of worthlessness or excessive or inappropriate guilt
- ☐ diminished ability to think/concentrate

However, the behaviors are not sufficiently intense to qualify for a depressive disorder.

These symptoms should be more than transient and have a mild impact on the child's functioning. Bereavement that continues beyond 2 months may also be a problem.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant may experience some developmental regressions, fearfulness, anorexia, failure to thrive, sleep disturbances, social withdrawal, irritability, and increased dependency, which are responsive to extra efforts at soothing and engagement by primary caretakers.

Early Childhood
The child may experience similar symptoms as in infancy, but sad affect may be more apparent. In addition, temper tantrums may increase in number and severity, and physical symptoms such as constipation, secondary enuresis (...), encopresis (...), and nightmares may be present.

Middle Childhood
The child may experience some sadness that results in brief suicidal ideation with no clear plan of suicide, some apathy, boredom, low self-esteem, and unexplained physical symptoms such as headaches and abdominal pain (...).

Adolescence
Some disinterest in school work, decrease in motivation, and day-dreaming in class may begin to lead to deterioration of school work. Hesitancy in attending school, apathy, and boredom may occur.

SPECIAL INFORMATION

Sadness is experienced by some children beyond the level of a normal developmental variation when the emotional or physiologic symptoms begin to interfere with effective social interactions, family functioning, or school performance. These periods of sadness may be brief or prolonged depending on the precipitating event and temperament of the child. Reassurance and monitoring is often needed at this level. If the sad behaviors are more severe, consider major depressive disorders.

The potential for suicide in grieving children is higher. Evaluation of suicidal risk should be part of a grief workup for all patients expressing profound sadness or confusion or demonstrating destructive behaviors toward themselves or others.

Behavioral symptoms resulting from bereavement that persist beyond 2 months after the loss require evaluation and intervention. Depressed parents or a strong family history of depression or alcoholism (...) puts youth at very high risk for depressive problems and disorders. Family and marital discord, ... exacerbates risk. Suicidal ideation should be assessed (see Suicidal Thoughts or Behaviors cluster).

Lying, stealing, suicidal thoughts (see Suicidal Thoughts or Behaviors cluster), and promiscuity may be present. Physical symptoms may include recurrent headaches, chronic fatigue, and abdominal pain (...).

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in primary Care.* (1996) American Academy of Pediatrics

Notes: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)*

DISORDERS

Major Depressive Disorder

Significant distress or impairment is manifested by five of the nine criteria listed below, occurring nearly every day for 2 weeks.

These symptoms must represent a change from previous functioning and that either depressed or irritable mood or diminished interest or pleasure must be present to make the diagnosis.

- ☐ depressed/irritable
- ☐ diminished interest or pleasure
- ☐ weight loss/gain
- ☐ insomnia/hypersomnia
- ☐ psychomotor agitation/retardation
- ☐ fatigue or energy loss
- ☐ feelings of worthlessness
- ☐ diminished ability to think/concentrate
- ☐ recurrent thoughts of death and suicidal ideation

(see *DSM-IV* Criteria ...)

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
True major depressive disorders are difficult to diagnose in infancy. However, the reaction of some infants in response to the environmental cause is characterized by persistent apathy, despondency (often associated with the loss of a caregiver or an unavailable (e.g., severely depressed) caregiver), nonorganic failure-to-thrive (often associated with apathy, excessive withdrawal), and sleep difficulties. These reactions, in contrast to the "problem" level, require significant interventions.

Early Childhood
This situation in early childhood is similar to infancy.

Middle Childhood
The child frequently experiences chronic fatigue, irritability, depressed mood, guilt, somatic complaints, and is socially withdrawn (...). Psychotic symptoms (hallucinations or delusions) may be present.

Adolescence
The adolescent may display psychomotor retardation or have hypersomnia. Delusions or hallucinations are not uncommon (but not part of the specific symptoms of the disorder).

SPECIAL INFORMATION

Depressed parents or a strong family history of depression or alcoholism puts youth at very high risk for depressive disorder (...). Risk is increased by family and marital discord (...), substance abuse by the patient (...), and a history of depressive episodes. Suicidal ideation should be routinely assessed.

Sex distribution of the disorder is equivalent until adolescence, when females are twice as likely as males to have a depressive disorder.

Culture can influence the experience and communication of symptoms of depression, (e.g., in some cultures, depression tends to be expressed largely in somatic terms rather than with sadness or guilt). Complaints of "nerves" and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or "imbalance" (in Chinese and Asian cultures), of problems of the "heart" (in Middle Eastern cultures), or of being heartbroken (among Hopis) may express the depressive experience.

Subsequent depressive episodes are common. Bereavement typically improves steadily without specific treatment. If significant impairment or distress is still present over 2 months following the acute loss or death of a loved one, or if certain symptoms that are not characteristic of a "normal" grief reaction are present (e.g., marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation), consider diagnosis and treatment of major depressive disorder.

DISORDER

Dysthymic Disorder

The symptoms of dysthymic disorder are less severe or disabling than those of major depressive disorder but more persistent.

Depressed/irritable mood for most of the day, for more days than not (either by subjective account or observations of others) for at least 1 year.

Also the presence, while depressed/ irritable, of two (or more) of the following:

- ☐ poor appetite/overeating
- ☐ insomnia/hypersomnia
- ☐ low energy or fatigue
- ☐ poor concentration/difficulty making decisions
- ☐ feelings of hopelessness

(see *DSM-IV* Criteria ...)

Adjustment Disorder With Depressed Mood

(see DSM-IV Criteria ...)

Depressive Disorder, Not Otherwise Specified

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Not diagnosed.

Early Childhood
Rarely diagnosed.

Middle Childhood and Adolescence
Commonly experience feelings of inadequacy, loss of interest/pleasure, social withdrawal, guilt, brooding, irritability or excessive anger, decreased activity/productivity. May experience sleep/ appetite/weight changes and psychomotor symptoms. Low self-esteem is common.

SPECIAL INFORMATION

Because of the chronic nature of the disorder, the child may not develop adequate social skills.

The child is at risk for episodes of major depression.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

DISORDER

Bipolar I Disorder, With Single Manic Episode

(see DSM-IV CRITERIA...)

Bipolar II Disorder, Recurrent Major Depressive Episodes With Hypomanic Episodes

Includes presence (or history) of one or more major depressive episodes, presence of at least one hypomanic episode, there has never been a manic episode (similar to manic episodes but only need to be present for 4 or more days and are not severe enough to cause marked impairment in function) or a mixed episode. The symptoms are not better accounted for by schizoaffective disorder, schizophrenia, delusional disorder, or psychotic disorder. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Not diagnosed.

Early Childhood
Rarely diagnosed.

Middle Childhood
The beginning symptoms as described for adolescents start to appear.

Adolescence
During manic episodes, adolescents may wear flamboyant clothing, distribute gifts or money, and drive recklessly. They display inflated self-esteem, a decreased need for sleep, pressure to keep talking, flights of ideas, distractibility, unrestrained buying sprees, sexual indiscretion, school truancy and failure, antisocial behavior, and illicit drug experimentation.

SPECIAL INFORMATION

Substance abuse is commonly associated with bipolar disorder (...).

Stimulant abuse and certain symptoms of attention-deficit/ hyperactivity disorder may mimic a manic episode (see Hyperactive/ Impulsive Behaviors cluster).

Manic episodes in children and adolescents can include psychotic features and may be associated with school truancy, antisocial behavior (...), school failure, or illicit drug experimentation. Long-standing behavior problems often precede the first manic episode.

One or more manic episodes (a distinct period of an abnormally and persistently elevated and expansive or irritable mood lasting at least 1 week if not treated) frequently occur with one or more major depressive episodes. The symptoms are not better accounted for by other severe mental disorders (e.g., schizoaffective, schizophrenegenic, delusional, or psychotic disorders). The symptoms cause mild impairment in functioning in usual social activities and relationships with others.

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

DISORDER

Suicidal Ideation and Attempts

The child has thoughts about causing intentional self-harm acts that cause intentional self-harm or death.

This code represents an unspecified mental disorder. It is to be used when no other condition is identified.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Unable to assess.

Early Childhood
The child expresses a wish and intent to die either verbally or by actions.

Middle Childhood
The child plans and enacts self-injurious acts with a variety of potentially lethal methods.

Adolescence
The adolescent frequently shows a strong wish to die and may carefully plan and carry out a suicide.

SPECIAL INFORMATION

A youngster's understanding that death is final is not an essential ingredient in considering a child or adolescent to be suicidal. However, very young children, such as preschoolers who do not appreciate the finality of death, can be considered to be suicidal if they wish to carry out a self-destructive act with the goal of causing death. Such behavior in preschoolers is often associated with physical or sexual abuse (...).

Prepubertal children may be protected against suicide by their cognitive immaturity and limited access to more lethal methods that may prevent them from planning and executing a lethal suicide attempt despite suicidal impulses.

The suicide rate and rate of attempted suicide increase with age and with the presence of alcohol and other drug use. Psychotic symptoms, including hallucinations, increase risk as well.

Because of societal pressures, some homosexual youth are at increased risk for suicide attempts (...).

In cases of attempted suicide that are carefully planned, adolescents may leave a note, choose a clearly lethal method, and state their intent prior to the actual suicide. In contrast, most suicide attempts in adolescence are impulsive, sometimes with little threat to the patient's life. The motivation for most attempts appears to be a wish to gain attention and/or help, escape a difficult situation, or express anger or love. However, irrespective of motivation, all suicide attempts require careful evaluation and all patients with active intent to harm themselves should have a thorough psychiatric evaluation.

Although suicidal ideation and attempts is not a disorder diagnosis, more extensive evaluation may identify other mental conditions (e.g., major depressive disorder).

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics.

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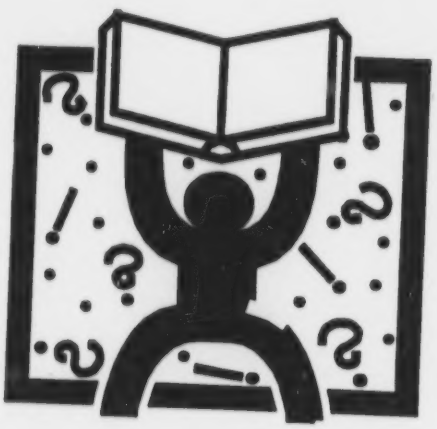
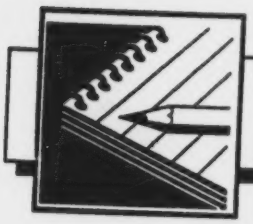
III. A Quick Overview of Some Basic Resources



A. A Few References and Other Sources of Information

B. Agencies and Online Resources Relevant to Affect and Mood-Related Problems and Disorders

C. Affect and Mood Problems: Consultation Cadre Contacts



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* See references in previous excerpted articles.

B. Agencies and Online Resources Relevant to Affect and Mood Problems

American Association of Suicidology

The American Association of Suicidology is a nonprofit organization dedicated to the understanding and prevention of suicide. This site is designed as a resource for anyone concerned about suicide, including AAS members, suicide researchers, therapists, prevention specialists, survivors of suicide, and people who are themselves in crisis.

Contact: Alan L. Berman, Ph.D., Executive Director, 4201 Connecticut Avenue, N.W. Suite 310 Washington, DC 20008 Voice: (202) 237-2280 Fax: (202) 237-2282
E-Mail: amyjomc@ix.netcom.com Web: http://www.suicidology.org

Center for Suicide Research and Prevention

Rush-Presbyterian-St. Luke's Medical Center, 1725 West Harrison Street, Suite 995, Chicago, IL 60612 Voice (312) 942-7208 Fax: (312) 942-2177

D/ART: Depression/Awareness, Recognition and Treatment

(D/ART), DEPRESSION; Awareness, Recognition, and Treatment is a federal government program to educate the public, primary care providers, and mental health specialists about depressive illnesses--their symptoms, diagnosis, and treatment. Sponsored by the National Institute of Mental Health (NIMH) and based on more than 50 years of medical and scientific research, D/ART is a collaboration between the government and community organizations to benefit the mental health of the American public.

Contact: D/ART, 5600 Fishers Lane, Rockville, MD 20857 Phone: 1-800-421-4211
Website: http://www.nimh.nih.gov/dart/index.htm

Depression Resource List

An easy to use site with lists of resources online related to depression, suicide, manic depression, panic and anxiety and treatment. Several support group websites listed for each topic.

Email: corbeau@execpc.com Web: http://www.execpc.com/~corbeau/

Depression.com

The editorial staff of Depression.com screens the latest news and research, reviews the dozens of depression-related sites in cyberspace, and provides an interactive forum for people who deal with it. Also provides quizzes and numerous topics filled with information about depression.

Website: http://www.depression.com/

DRADA (Depression and Related Affective Disorders Assn)

DRADA's mission is to alleviate the suffering arising from depression and manic depression by assisting self-help groups, providing education and information, and lending support to research programs. DRADA works in cooperation with the Department of Psychiatry at the Johns Hopkins University School of Medicine, which helps us ensure that our materials are medically accurate, as well as co-sponsoring our annual mood disorders research/education symposiums.

Contact: 600 N. Wolfe St., Baltimore, MD 21287-7381
Phone: (410) 955-4647 or (202) 955-5800 FAX: (410) 614-3241
Email:drada@welchlink.welch.jhu.edu Website: http://www.med.jhu.edu/drada/

MDSG-NY (Mood Disorders Support Group, Inc.)

This site is Internet's central clearing house for information on all types of depressive disorders and on the most effective treatments for individuals suffering from Major Depression, Manic-Depression (Bipolar Disorder), Cyclothymia, Dysthymia and other mood disorders.

Contact: P.O. Box 1747, Madison Square Station, New York, NY 10159
Phone: (212) 533-MDSG; FAX: (212) 475-5109. Website:
http://www.mdsg.org

Mental Health Net (MHN)

Mental Health Net (MHN) is a comprehensive, fun, and useful guide to every mental health topic imaginable, with over 3,000 individual resources listed. The information found here is for everyone associated with mental health. Topics covered on MHN range from disorders such as depression, anxiety, and substance abuse, to professional journals and self-help magazines that are available online.

Website:http://www.mentalhelp.net

Moodswing org.

Online resources for people with Bipolar (and friends and family). Home of the Bipolar Disorder Frequently asked Questions.

Website: http://www.moodswing.org.

Also, don't forget to check with our Sister Center:

Center for School Mental Health Assistance (CSMHA) at the University of Maryland at Baltimore

Contact: Mark Weist, Ph.D. (Director)
Olga Acosta (Coordinator)
Dept. of Psychiatry
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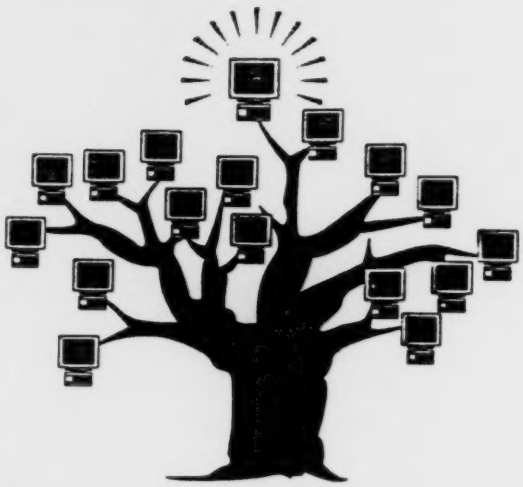

National Depressive and Manic-Depressive Association

The mission of the National Depressive and Manic-Depressive Association is to educate patients, families, professionals, and the public concerning the nature of depressive and manic-depressive illness as treatable medical diseases; to foster self-help for patients and families; to eliminate discrimination and stigma; to improve access to care; and to advocate for research toward the elimination of these illnesses.

Contact: 730 N. Franklin, #501,Chicago, IL 60610

Phone: 800-826-3632 or (312) 42-0049; FAX: (312)642-7243.

Website: http://www.ndmda.org/

The Samaritans

A non-religious charity that has been offering emotional support to the suicidal and despairing for over 40 years by phone, visit and letter. Callers are guaranteed absolute confidentiality and retain the right to make their own decisions including the decision to end their life. The service is available via E-mail, run from Cheltenham, England, and can be reached from anywhere with Internet access. Trained volunteers read and reply to mail once a day, every day of the year.

Contact: 10 The Grove, Slough, Berkshire SL1 1QP

Phone: 01753 216500 Fax: 01753 775787

Email: jo@samaritans.org Website: http://www.samaritans.org.uk/

SA\ VE: Suicide Awareness \ Voices of Education

This website provides educational materials on suicide prevention and untreated depression.

Contact: Joseph H. Talley, M.D., P.O. Box 24507, Minneapolis, MN 55424-0507

Phone: (612) 946-7998 Email: save@winternet.com

Website: http://www.save.org

Teens-Depression and Suicide Prevention

This website provides information and resources on depression and suicide prevention.

Phone: (800) 554-8336 Email: whitel@trfn.clpgh.org

Website:http://trfn.pgh.pa.us/Populations/ya/depression.html

Affect and Mood Problems Related to School to School aged Youth
Consultation Cadre List

Professionals across the country volunteer to network with others to share what they know. Some cadre members run programs, many work directly with youngsters in a variety of settings and focus on a wide range of psychosocial problems. Others are ready to share their expertise on policy, funding, and major system concerns. The group encompasses professionals working in schools, agencies, community organizations, resource centers, clinics and health centers, teaching hospitals, universities, and so forth.

People ask how we screen cadre members. We don't! It's not our role to endorse anyone. We think it's wonderful that so many professionals want to help their colleagues, and our role is to facilitate the networking. If you are willing to offer informal consultation at no charge to colleagues trying to improve systems, programs, and services for addressing barriers to learning, let us know. Our list is growing each day; the following are those currently on file related to this topic. Note: the list is alphabetized by Region and State as an aid in finding a nearby resource.

Updated 8/15/01

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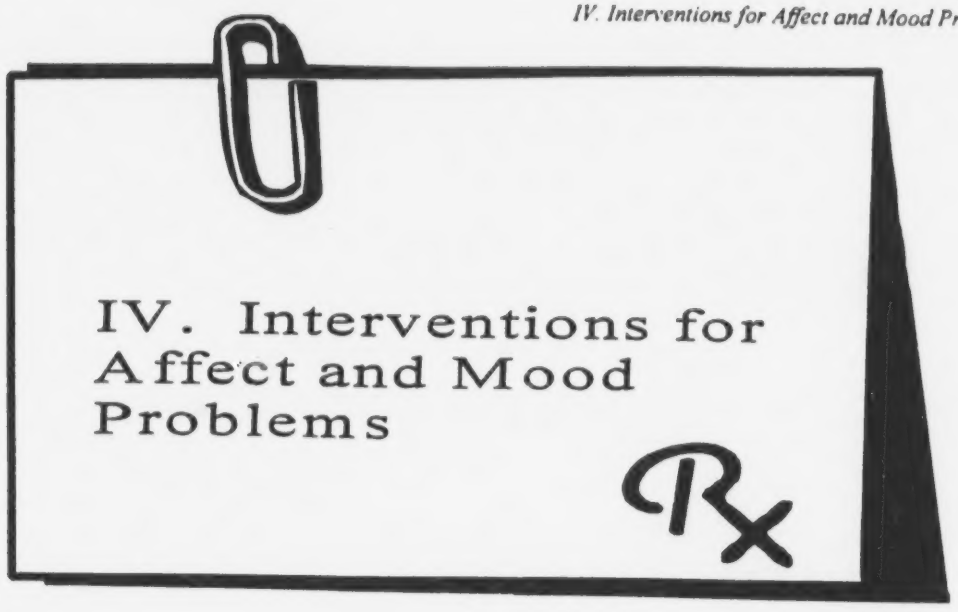

On the following pages are discussions of

- *Accomodations to Reduce Affect and Mood Problems: Children and Depression*
- *Behavior Management: Suicide Crisis*
- *Best practices in Suicide Intervention*
- *Approaches to Those Who are Suicidal*
- *Empirically Supported Treatments for Affect and Mood Problems*
- *Medications Used to Treat Affect and Mood Problems*

Accommodations to Reduce Affect and Mood Problems

Children and Depression

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➠Background

Depressed mood is a common and universal part of human experience that can occur at any age and has various causes. Over time, many children report or give the appearance of feeling unhappy, sad, dejected, irritable, "down" or "blue" but most of them quickly and spontaneously recover from these brief and normal moods or emotional states. However, for others, the depression can be severe and long lasting, and interfere with all aspects of daily life from school achievement to social relationships.

The incidence of more severe depression in children is probably less than 10% although exact figures are not known. Girls are more likely than boys to develop mood disorders. The associated risk of suicide increases significantly during adolescence.

➠Development

Recognizing and diagnosing childhood depression is not always an easy task. The onset of depression can be gradual or sudden, it may be a brief or long term episode, and may be associated with other disorders such as anxiety. The presence of one or two symptoms is not sufficient evidence of a depressive disorder. It is when a group of such symptoms occur together over time that a more serious mood disorder should be considered. The DSM-III- R manual published by the American Psychiatric Association classified depression according to severity, duration and type.

The definition of major depression requires the presence of five or more of the following symptoms for at least two weeks. One or both of the essential features of depressed or limitable mood, and loss of interest or pleasure in almost all activities must be observed. Other symptoms include appetite disturbance and significant weight loss or gain, sleep difficulties or too much sleep, slow or agitated and restless behavior (many depressed children become overly aggressive), decreased energy or fatigue, feeling of worthlessness or self-blame and guilt, concentration and thinking difficulties, and thoughts of death or suicide.

Less severe forms of depression include dysthymia (moderately depressed mood over one year) and adjustment disorder with depressed mood caused by some known stress and lasting less than 6 months. Depressive features will vary in relation to the age and developmental level of the child. For example, physical complaints, agitation, anxiety and fears are more often seen in younger children while adolescents are more likely to engage in antisocial behavior or become sulky, overly emotional, and withdrawn.

There are a number of suggested causes of childhood depression. Biological explanations of depression have examined the roles of hereditary, biochemical, hormonal, and brain factors. More recently, the amount of light associated with seasonal changes has been suspected to affect mood.

Psychological descriptions have linked depression to the loss of loved ones, disturbances in parent-child relationships, and threats to self-esteem. Attention has also been focused on the way children interpret and structure everyday experiences and the belief they have about their ability to control and shape their world. Any of a number of psychological stressors may be able to significantly affect the mood of some children.

Given the various kinds and causes of childhood depression, there are different treatments that may be required. The "treatment" for the disappointment that follows the loss of a ball game may be a visit to the local hamburger restaurant, or the feelings of failure and

irritability caused by a poor school mark could signal the need to improve study habits and pay closer attention in school. When the signs of depression described above occur and persist, the professional assistance of a psychologist or psychiatrist should be obtained. Antidepressant (tricyclics and MAO inhibitors) and antianxiety medications are very beneficial in the treatment of severe depression. Several effective forms of psychological treatment include behavioral, cognitive-behavioral, and interpersonal (IPT) therapy. Combined medication and psychotherapy programs are frequently employed in the treatment of depression.

➡What can I do as a parent?

The list of suggestions follows the most frequently cited symptoms of childhood depression.

—Self-esteem and self-critical tendencies: give frequent and genuine praise; accentuate the positive; supportively challenge self-criticism; point out negative thinking.

—Family stability: maintain routine and minimize changes in family matters; discuss changes beforehand and reduce worry.

—Helplessness and hopelessness: have the child write or tell immediate feelings and any pleasant aspects 3 or 4 times a day to increase pleasant thoughts over 4-6 weeks.

—Mood elevation: arrange one interesting activity a day; plan for special events to come; discuss enjoyable topics.

—Appetite and weight problems: don't force eating; prepare favorite foods; make meal-time a pleasant occasion.

—Sleep difficulties: keep regular bed-time hours; do relaxing and calming activities one hour before bed-time such as reading or listening to soft music; end the day on a "positive note."

—Agitation and restlessness: change activities causing agitation; teach the child to relax; massage may help; encourage physical exercise and recreation activities.

—Excessive fears: minimize anxiety-causing situations and uncertainty; be supportive and reassuring; planning may reduce uncertainty; relaxation exercises might help.

—Aggression and anger: convey a kind but firm unacceptance of destructive behavior; encourage the child to his angry feelings; do not react with anger.

—Concentration and thinking difficulties: encourage increased participation in games, activities, discussions; work with the teachers and school psychologist to promote learning.

—Suicidal thoughts: be aware of the warning signs of suicide; immediately seek professional help.

—if depression persists: consult your family doctor for a complete medical exam; seek a referral to a psychologist or psychiatrist.

Resources

Depression and Its Treatment—by Drs. J. H. Greist and J. Jefferson, 1984. This is a very readable layman's guide to understanding and treating depression.

Stress, *Sanity and Survival—by* Drs. R. L. Woolfolk and F. C. Richardson, 1978. Numerous suggestions are given for dealing with worry, anger, anxiety, inadequacy and other signs of stress associated with depression.

Three Steps Forward: Two Steps Back—by C. R. Swindel, 1980. Written from a religious perspective, this book offers practical ways to face problems such as loss, anxiety, self-doubt, fear and anger.

Control Your Depression—by Dr. P. Lewinsohn, 1979. This leading expert offers meaningful and helpful suggestions based on his theory of depression.

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Behavioral Management: Suicide Crisis

In developing our Center's Resource Aid Packet on *Responding to Crisis at a School,* we were impressed by the good work being done by so many people around the country. The unfortunate fact that so many students feel despair and consider suicide has resulted in important common practices at school sites.

Changing systems in schools to support students and reduce unnecessary stress is the first line of defense. However, when concerns arise about a specific student, school staff must be ready to respond. The suicide assessment and follow-through checklists in the next section are a compilation of best practices and offer tools to guide intervention.

When a Student Talks of Suicide . . .

You must assess the situation and reduce the crisis state (see Suicidal Assessment Checklist in section V). The following are some specific suggestions.

What to do:

- Send someone for help; you'll need back-up.
- Remain calm; remember the student is overwhelmed and confused as well as ambivalent.
- Get vital statistics, including student's name, address, home phone number and parent's work number.
- Encourage the student to talk. Listen! Listen! Listen! And when you respond, reflect back what you hear the student saying. Clarify, and help him or her to define the problem, if you can.

Consider that the student is planning suicide. How does the student plan to do it, and how long has s/he been planning and thinking about it? What events motivated the student to take this step?

- Clarify some immediate options (e.g., school and/or community people who can help).
- If feasible, get an agreement to no-suicide ("No matter what happens, I will not kill myself.")
- Involve parents for decision making and follow-through and provide for ongoing support and management of care (including checking regularly with parents and teachers).

What to avoid:

- Don't leave the student alone and don't send the student away
- Don't minimize the student's concerns or make light of the threat
- Don't worry about silences; both you and the student need time to think
- Don't fall into the trap of thinking that all the student needs is reassurance
- Don't lose patience
- Don't promise confidentiality -- promise help and privacy
- Don't argue whether suicide is right or wrong

When a Student Attempts Suicide . . .

A student may make statements about suicide (in writing assignments, drawing, or indirect verbal expression). Another may make an actual attempt using any of a variety of means. In such situations, you must act promptly and decisively.

What to do:

- Be directive. Tell the student, "Don't do that; stand there and talk with me." "Put that down." "Hand me that." "I'm listening."
- Mobilize someone to inform an administrator and call 911; get others to help you; you'll need back-up.
- Clear the scene of those who are not needed. An "administrator" should contact parents to advise them of the situation and that someone will call back immediately to direct the parent where to meet the youngster.
- Look at the student directly. Speak in a calm, low voice tone. Buy time. Get the student to talk. Listen. Acknowledge his or her feelings "You are really angry." "You must be feeling really hurt."
- Secure any weapon or pills; record the time any drugs were taken to provide this information to the emergency medical staff or police.
- Get the student's name, address and phone.
- Stay with the pupil; provide comfort.
- As soon as feasible, secure any suicidal note, record when the incident occurred, what the pupil said and did, etc.
- Ask for a debriefing session as part of taking care of yourself after the event.

What to avoid:

- Don't moralize ("You're young, you have everything to live for.")
- Don't leave the student alone (even if the student has to go to the bathroom).
- Don't move the student.

In all cases, show concern and ask questions in a straightforward and calm manner. Show you are willing to discuss suicide and that you aren't appalled or disgusted by it. Open lines of communication. Get care for the student.

Read Some More

Adolescent Suicide: Assessment and Intervention by A.L. Berman & D.A. Jobes (1991). Washington, D.C.: American Psychological Association.

Youth Suicide: A Comprehensive Manual for Prevention and intervention by B.B. Hicks (1990). Bloomington, IN: National Educational Service

Best Practices in Suicide Intervention

Excerpts from Chapter 41 in *Best Practices in School Psychology-III*, 1995
By Scott Poland, Cypress-Fairbanks (Texas) Public Schools
Edited by A. Thomas & J. Grimes
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OVERVIEW AND SCOPE OF THE PROBLEM

Completed Suicides

Much has been written about the increasing numbers of suicidal youth and of completed suicides. It is important that school psychologists have accurate information about the extent of the problem. The Center for Disease Control (CDC) in Atlanta, Georgia, compiles data on suicides and publishes reports annually detailing the incidence rates by age categories and state of residence.

Berman and Jobes (1991) pointed out that the suicidal behavior of young people over the past 30 years has generated a great deal of public concern. They emphasized the high suicide rate for young people between the ages of 15 and 24. Specifically there has been a 312% increase in the youth suicide rate from 1967 to 1987 for youth ages 15 to 19. The CDC (1992) pointed out that the youth suicide rate remains at or near an all-time high. Over the past decade suicide has been either the second or third leading cause of death for young people. The leading cause of death for young people has remained accidents with suicide and homicide exchanging places from year to year. In 1992 the CDC listed suicide as the third leading cause of death for youth under the age of 19.

Suicide rates vary by age, sex, and race. School psychologists are logically the most concerned about the suicide rate for school-age youth 5 to 19. Suicide rates are reported per 100,000 for each age range. The United States had 30,906 completed suicides in 1990 of which 4,869 or 13.3% were completed. by young people ages 15 to 24 with an incidence rate of 12.4 per 100,000 (National Center for Health Statistics, 1993). Berman and Jobes (1991) cited an incidence rate of 98 per 100,000 in the 10 to 14 age group, and no incidence figures for youth under the age of 10 reported for the same year, 1989. A national goal has been set to reduce the youth suicide rate by the year 2000 but there appears to be little progress and Pfeffer (1986) predicted a 94% increase in the 15- to 19-year-old category by the year 2000.

Suicidal Ideation

This chapter's author (Poland, 1989) reviewed a number of national surveys of high school students. They indicated that, across the nation, between 8% and 14% of all high school students reported an attempted suicide and 25% to 35% admitted to suicidal thoughts. The CDC (1992) found the following data Dn high school students:

- Eight percent had already attempted suicide.
- Twenty-seven percent had seriously contemplated it.
- Sixteen percent had made a plan to commit suicide.

Davis and Sandoval (1991) reviewed figures on incidence and attempts and estimated the following prediction for a high school of 2,000 students.

- One suicide every 5 years.
- 168 to 400 annual attempts.

There is not much information available on the extent of suicidal ideation of elementary- and middle-school-aged students. My earlier report (Poland, 1989) indicated that the suicide of young people under the age of 10 is rare and the most cited explanations for lower incidence when compared to adolescents are:

- Less depression, alienation, and loneliness.
- More involvement with parents.
- Less drug and alcohol involvement.
- Less access to firearms.

School psychologists are encouraged to become familiar with incidence figures from their county and state. It is also important to be aware of racial and regional differences in suicide rates. Suicide rates are higher in western states of the United States which have a high Native American population. Leenaars and Wenckstern (1991) also pointed out that many researchers feel that governmental figures are actually an underestimation of the problem. Added to that is the fact that schools can be greatly affected by the suicides of individuals other than students such as a parent, teacher, neighbor, or sibling (Poland, 1989).

BASIC CONSIDERATIONS

Youth suicide has many implications for the schools. Laws in 12 states address the role of the school in prevention (Nguyen & Siver, 1993), and most states are studying the problem of youth suicide. No national legislation has been passed although the federal government sponsored a national conference in 1985. The strongest proponent for national legislation has been U.S. Representative Ackerman (1993) who emphasized that the federal government must fund youth suicide prevention efforts and encourage cooperation at all levels of government

The question of the responsibility of the schools with regards to youth suicide is not a new one. Stekel, a social scientist, commented on an outbreak of youth suicide in Europe in the early 1900s, "The school is not responsible for the suicide of its pupils, but it also does not prevent these suicides. This is its only, but perhaps its greatest sin" (quoted in Peck, Farberow, & Litman, 1985, p. 158). Few schools are prepared to deal with youth suicide, and not enough policies and procedures have been written to clarify the role of school personnel (Harris & Crawford, 1987; Poland, 1989). Ross (1985) stressed that it is fear and not lack of concern that results in school administrators being reluctant to work on this problem. Few school administrators have received any formal training in suicide prevention. They believe many misperceptions about youth suicide and see it as a problem that happens elsewhere.

School prevention programs began in California in the 1970s and have spread by a grassroots effort with each school re-inventing the wheel (Ryerson, 1988). It is evident that school psychologists are the first professionals school personnel are going to turn to when they feel that a student might be suicidal. Davis and Sandoval (1991) cited one study that found that 79% of teachers would turn to the school psychologist first for assistance. Therefore, school psychologists are in a position to clarify the schools' role and write policies and procedures to work on this problem. Several writers emphasize that intervention programs in the school are effective (Cantor, 1987; Guetzloe, 1989; Leenaars & Wenckstern, 1991; Ross, 1985; Ruof & Harris, 1988....

Forces and Factors in Youth Suicide

Space does not permit a detailed examination of he numerous forces and factors that school psychologists need to be aware of (see, instead, Poland, 989).

However, the following section indicates the labor events and circumstances in youth suicide. A precipitating event may cause a young person to act n suicidal thoughts. The most common precipitating events involve arguments with parents, boyfriends or girlfriends, or the loss of a loved one (Eyeman, 1987; Porter, 1985). Shaffer (1988) stressed that discipline incidents and loss of face with peers are also factors.

Depression has long been considered the most important warning sign of suicide. Numerous researchers stress that depression in children does exist but does not account for all youth suicides. Conduct disordered adolescents are also at risk to commit suicide (Eyeman, 1987; Shaffer, 1988).

Substance abuse is now known to play an important role in youth suicide. Substance usage may cause a young person to lose contact with reality and increases the chance of a suicide attempt. Alcohol and many other drugs are depressants which only add to a young person's problems. Davis, Sandoval, and Wilson (1988) suggest that substance abuse be added as a major warning sign of suicide.

Students who run away also may be at risk for suicide. Researchers have found that runaways attempt suicide approximately 20% of the time (Engleman, 1987; Fortinsky, 1987).

How children develop their concept of death is important. The young child may view death as something that is either reversible or only happening to the very old (Davis, 1985; Pfeffer. 1986). Adolescents may also have some misperceptions about the finality of death. Young children who talk about life-threatening, risk-taking behavior need to understand the possibly fatal consequences. The school psychologist should inquire as to the beliefs that the suicidal young person has about death. The young person who has spent lots of time imagining the reaction of others to his or her suicide may be at high risk to commit suicide (Davis, 1985; Poland, 1989).

Some youngsters' suicidal behavior is attention getting and manipulative. Barrett (1985) stressed that parents need to recognize that the young person wants something to change and parents should let themselves be manipulated until they get profession-al help.

Other factors that may greatly influence a particular child include:

1. Suicidal statements or suicide attempts by a parent.
2. Motion pictures that deal with suicide.
3. Suicidal song lyrics.
4. News coverage that glamorizes or mysticizes a suicide.

There has been a dramatic change in the methods employed to commit suicide by young people. Females are increasingly committing suicide by using guns. A strong correlation has been found between gun ownership and suicide with guns involved in approximately 60% of all suicides (Lester, 1988; Loftin, C., McDowell, D., Wlersema, B., & Cottey, T. 1991). The dramatic three-fold increase in youth suicide since the 1950s is almost entirely attributable to the increase in suicide by firearms according to Perper, Allman, Moritz, Wartella, and Zelenak (1991). Many professionals believe the single greatest factor to reduce youth suicide would be decreasing handgun access to troubled youth. Loftin et al. (1991) cited growing research demonstrating that handgun control legislation reduces the youth suicide rate. The CDC (1992) reported that none of the youth suicide prevention programs surveyed addressed restricting access to guns despite the evidence of its

effectiveness. School psychologists will be in a position to address gun availability with young people and their parents and need to be specific about the need to remove guns from troubled youth. One teenager in good-bye note to her parents questioned why they made suicide so easy by leaving a gun available(Poland, 1989).

There is no single factor or cause that explains youth suicide. Siebel and Murray (1988) stress that re may be as many as 28 factors or causes. School personnel need to be aware of these factors, and if at concerned about a particular student, they need to inquire further.

BEST PRACTICES

Developing a Suicide Intervention Program

Every school system needs a written policy to clarify the school's role. These procedures need to address the three levels of intervention outlined by Caplan (1964) and elaborated on by Poland, Pitcher, and Lazarus in the chapter in this volume on Crisis Intervention. These three levels—primary prevention, secondary intervention, and tertiary intervention - correspond well with the terms utilized in the suicidology literature of *prevention, intervention,* and *postrention.*. Vidal (1986) stressed that help for a suicidal student is contingent on school personnel knowing the policy. The obligations of the school at a *minimum* are (see Poland, 1989, for more detail):

1. Detect suicidal students.
2. Assess the severity level of their suicidal symptoms.
3. Notify parents.
4. Secure the needed mental health services and supervision for the student.
5. Follow-up at school.

Detection

All school personnel including bus drivers and aides need information on the warning signs of suicide as identified by the American Association of Suicidology (AAS; 1977). These warning signs include the following verbal and behavioral clues:

1. Suicide threats or statements.
2. An attempt at suicide.
3. Prolonged depression.
4. Dramatic change of behavior or personality.
5. Making final arrangements.

School personnel should be encouraged to reach out to help suicidal students and should follow district policy in referring students. School personnel must not keep a secret about suicidal behavior and need to understand the situational nature of youth suicide. They should feel empowered that they could save a life as in the case example.

Assessment

School personnel must be skilled at assessing the severity level of a suicidal student's symptoms. The most logical personnel to do this are school psychologists. They need to be prepared for whenever suicidal issues may come up by working through personal issues and perceived inadequacies in this area and by investigating the various suicidal assessment scales. It may be advisable to rehearse with a colleague or even a drama student intervening with a suicidal individual.

There is no one scale or set of questions recommended for use with a suicidal student. Davis et al. (1988) reviewed the available instruments. Although they cautioned that more validation needs to be done, they noted the following instruments as the most promising ones:

1. The Hilson Adolescent Profile developed by Inwald, Brobst, and Morrisey (1987).
2. The Suicidal Ideation Questionnaire developed by Reynolds (1987).
3. The Suicide Probability Scale developed by Cull and Gill (1982). ...

Parent Notification

Parents must be notified any time it is believed that a child is suicidal. The question is not whether to call them but instead what to say to them. The goal of parent notification is to safeguard the welfare of the student. The school psychologist who notifies parents is also protecting himself or herself from liability. School districts and school employees have been sued for inadequate suicide prevention programs.

Slenkovitch (1986) has stressed that schools Could never take a suicide threat lightly. Davidson 1985) and Henegar (1986) discuss the question of liability. They clarified the importance of one's duty to care and the foreseeability of a client's actions and stated that the primary issue is negligence. Henegar Cemented in part, "a negligence theory in a suicide case is not generally a claim that one caused the suicide but rather that one did not take reasonable steps prevent it" (1986, p. 4). Henegar made several recommendations that have implications for school psychologists.

1. Increase supervision of the student.
2. Limit access to self-destructive instrunnents.
3. Obtain psychological treatment for the student.....

Community Services

School psychologists need to be familiar with community resources to assist suicidal students. A goal should be to establish a cooperative relationship between the school, the parent, and the community mental health provider so that maximum support is provided to the student. The school

psychologist should not accept the primary responsibility of treating a suicidal student although he or she will need to continue to provide support and monitoring at school even though the student is receiving community services.

Summary of Intervention

The key points in the intervention process can be summarized as follows:

1. Try to remain calm and seek collaboration from a colleague.
2. Gather case history information from the student and approach the student as if he or she were planning a trip.
3. Ask specific questions about the suicidal plan and the frequency of suicidal thoughts and remove any lethal weapons.
4. Emphasize that there are alternatives and the student is not the first person to feel this way.
5. Do not make any deals with the student to keep the suicidal thoughts or actions a secret and explain your ethical responsibility to notify the parents of the student.
6. Have the student sign a NO-SUICIDE CONTRACT and provide the student with the phone number of the local crisis hot-line.
7. Supervise the student until parents have assumed responsibility. (Poland, 1994)

Postvention

Schools are frequently not prepared to deal with e aftermath of a suicide yet few events are more disruptive. Experts have emphasized that a series of planned steps must take place to minimize the chances of a second suicide and to help students and faculty deal with their grief (Kneisel & Richards, 1988; Lamb & Dunne-Maxim, 1987; Leenaars & Wenckstern, 1991). Postvention policies need to be in place prior a suicide. Numerous writers have emphasized that the suicide must be acknowledged and discussed (Biblarz, 1988; Davis & Sandoval, 1991; Ryerson, 1988). Normal procedures in the event of a death should be followed with an emphasis on avoiding a dramatic romantic, or mystic treatment of the suicide. The task facing most school survivors is grief resolution. Homeroom discussions need to provide an opportunity for students to express their grief. Lamartine (1985) pointed out that the suicide of a student increases the probability 300% that a second suicide will occur. School psychologists need to identify other students at risk to commit suicide and provide assistance to them. Everyone at school needs to know the warning signs of suicide and to feel empowered to prevent further suicides. The following postvention guidelines were developed by the American Association of Suicidology (AAS; 1991);

1. Don't dismiss school or encourage funeral attendance during school hours.
2. Don't hold a large-scale school assembly or dedicate a memorial to the deceased.
3. Do provide individual and group counseling.
4. Verify the facts and do treat the death as a suicide.
5. Do contact the family of the deceased.
6. Do emphasize that no one is to blame for the suicide.
7. Do emphasize that help is available and that suicide is preventable and everyone has a role to play in prevention.

The AAS Postvention Guidelines (1991) also contain a number of recommendations for the media There is growing national awareness that dramatic media coverage of youth suicide may contribute to the cluster phenomenon. Specific AAS suggestions for the media are:

1. Avoid details of the method and front-page coverage.
2. Do not report the suicide as unexplainable or the results of simplistic causes.
3. Do not print a photograph of the deceased.
4. Include positive outcomes of suicidal crises and emphasize where suicidal youth may obtain help.

Youth suicide is not news in most of our large cities unless several suicides occur in the same school. The fact that it is not news is a blessing but a sad commentary on the times. Much is still not known about suicide clusters and contagion although the Center for Disease Control is in the midst of a several-year study.

School psychologists do need to know that not everyone agrees with guidelines developed by the MS. In particular, recommendations made by the Phi Delta Kappa Organization (1988) are in conflict on key points. Phi Delta Kappa recommended that the death not be treated as suicide and suggested that all concerned be forbidden to use the word "suicide" in order to protect the privacy of the family. A school administrator who has not thoroughly researched this area might follow these guidelines which also call for having all students who want more information about death to gather in a large assembly. This leads to dramatization and glorification of the suicide.

Curriculum Issues

Curriculum approaches to suicide prevention fall into two categories. The first approach emphasizes a positive school climate; affirms life; and promotes life skills for students, especially problem solving (Sowers, 1987). All professionals agree with the importance of this approach. The second approach involves directly talking in the classroom about suicide as a mental health problem (California State Department of Education, 1987). These classroom presentations emphasize the warning signs, befriending skills, friend intervention, and the situational nature of suicide. Also included are the relationship between suicide and substance usage and community services available to help a suicidal youth.

There is debate about whether such an approach is

recommended. Shaffer (1988) and colleagues Vieland, Whittle, Garland, Hicks, and Shaffer (1991) called for a moratorium on such curriculum presentations and noted that they were developed because the schools felt a need to do something. Smith (1988) commented on Shaffer's research and noted that most students who participate in curriculum programs view them positively. Holtzman (1991) cautioned against prematurely stopping curriculum presentations to prevent youth suicide and emphasized the limitations of the research done by Shaffer and colleagues and that all concerned were upset about newspaper headlines that suicide preventive programs were harmful to young people. The central issue to this controversy seems to be that curriculum presentations somehow plant the idea of suicide. This point is at the basis of Schafly's (1985) objections to curriculum presentations. A logical question is, can teenagers translate information presented to them into life-saving behavior?" Numerous evaluators have said "yes" to this question.

The question of whether parent permission should be obtained prior to a student participating in a curriculum presentation has been raised as well as the relevance of the Hatch Amendment (Davis et al., 1988; Shafly, 1985). Florida requires parent permission, for example, while California does not. An unfortunate consequence of the curriculum debate is that many school districts have misinterpreted the debate to mean that professionals do not agree on schools needing to prepare and take systematic steps to prevent youth suicide. This is not the case and no debate exists about the basic role of the school in detecting and assisting suicidal youth.

School psychologists need to be involved in determining the need for curriculum presentation in their district and selecting materials if presentations are to be provided to students. My 1989 book describes in detail how a school psychologist can design a carefully integrated mental health unit on suicide which addresses the biggest professional frustration that friends always knew about the suicidal actions of the deceased but unfortunately did not look to adults for help. There is every indication that with adult professional assistance the majority of youth suicides could be prevented.

The Center for Disease Control (1992) reviewed curriculum approaches to prevent youth suicide and summarized the following research findings:

1. Participants had short-term increases in knowledge about suicide prevention and knew more about mental health referral sources.
2. here is no evidence of increased suicidal behavior on the part of program participants.
3. The highest risk is that students may react negatively, and school personnel should be ready to assist any student who finds the program upsetting.

CDC recommends that suicide prevention programs be incorporated into existing health curricula rather than a highly visible special program. Programs were typically only 1 to 3 hours in length, and professionals must be cautious about what can be expected from a brief presentation. No program surveyed sought to measure changes in behavior such as students refer-ring themselves or friends for assistance.

SUMMARY

The problem of youth suicide is at or near an all-time high but is somewhat overshadowed by concerns about other problems that face young people today such as violence, drugs, poverty, teen pregnancy, and AIDS. Many of these problems are inextricably linked. School psychologists have historically not been trained in suicide intervention despite the fact that they are the first professionals school personnel turn to for assistance in this area. It is important that school psychologists provide leadership to help schools respond to the problem of youth suicide. The following recommendations from the Center for Disease Control (1992) should guide the actions of school psychologists.

1. School programs need to link up more with community resources.
2. More programs need to focus on reducing access to lethal weapons, especially guns.
3. To address high-risk youth, suicide prevention programs need to be linked with other programs such as alcohol, dropout, and pregnancy programs.
4. The lack of evaluative data on prevention programs is a great obstacle to improving prevention efforts.
5. Programs need to be developed to focus not only on school-aged youth but also on the 20 to 26 year-old population who have a suicide rate twice t hat of teens.
6. Schools need carefully written policies and procedures to address the problem of youth suicide, and school personnel need training on the warning signs of suicide.

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Provides the information needed to train school personnel to detect suicidal behavior. The lesson guide provided is appropriate to use in the curriculum for grades 9-12, emphasizing warning signs of suicide, community resources, and intervention by friends.

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The authors discuss both theoretical and practical aspects of managing crises in the schools. The role of the psychologist ranges from that of consultant to trainer to provider of direct service. Practical information regarding staff in-service, managing, organizational crises directly, and stimulating intrasystemic change is presented. Special emphasis on moving the system in the direction of providing preventive services is emphasized.

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The role of the school is defined, and case examples provide step-by-step guidelines for setting up and maintaining a comprehensive program. Issues covered include forces and factors in youth suicide, assessment, parent notification, liability, legislation, curriculum, and dealing with the media. Detailed procedures for intervention following crises is provided.

Center for Disease Control. (1992). *Suicide prevention programs: A resource guide.* Atlanta Author.

This resource guide was the result of a national networking effort to locate exemplary youth suicide prevention programs. Eight major prevention strategies are outlined with discussion of findings and recommendations for the future.

Poland, S. *(1994). Crisis intervention resource and training guide.* Author.

This guide gives a complete overview of all levels of crisis intervention and includes practical examples of program development. A variety of school crisis scenarios are covered in detail including suicide, violence, and gangs. This guide includes numerous overheads designed to assist school psychologists to give in-service presentations and help them develop district and building plans.

Davis, J., & Sandoval, S. (1991). *Suicidal youth School-based intervention and prevention* San Francisco: Jossey-Bass.

The authors review research and clinical practices in youth suicide. Guidelines are provided for determining suicide potential and developing suicide awareness school programs.

Approaches to Those Who Are Suicidal

Excerpts from: ***An Overview of the School-Based Prevention of Adolescent Suicide***

by: *Jonathan Sandoval, UC Davis*
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Milton P. Wilson, CA State Dept of Education

When a student who is exhibiting the warning signs of suicide is identified, it is important to make some kind of immediate contact with the student. Remaining silent and ignoring these behaviors are the worst things that one can do. An open discussion will rarely make a situation worse. The first step in suicide prevention at this level is to begin an open and frank discussion about how the individual is feeling. It is particularly important to avoid "trying to talk someone out of suicide." For example, it is a mistake to tell a student, "Everything will be all right," "You will feel better in the morning," or "You really have a great deal to live for and are fortunate compared to others in the world." Giving messages of this kind make the individual feel even more worthless and hopeless than before.

Most school personnel do not have the training to intervene for a long period of time with suicidal individuals. Typically an outside referral is called for. Community agencies and medical resources usually are staffed with individuals who are expert in working with depressed and suicidal individuals. Consequently an important goal of counseling a suicidal individual is to prepare the individual for such a referral. The student must be approached and encouraged to speak confidentially with an expert in helping to solve problems such as those the individual is experiencing. In addition to listening and being generally supportive while the referral is being arranged, the school special services worker must evaluate whether or not immediate action must be taken. This suicide evaluation should consist of assessing nine different areas (Davis, 1985).

First, and most important, *get a sense of suicidal potential.* Determine how likely the individual is to follow up on any thoughts about suicide he or she may have. Have the thoughts been present for a long time? Does the individual seem depressed?

Second, *learn about the existence of a suicidal plan.* The more detailed and sophisticated a plan for committing suicide may be, the more serious the referral and the more likely one should recommend immediate hospitalization.

Third, *examine past suicide attempts carefully.* Discuss any attempts the student has made as well as attempts made by significant others. The fact that significant persons in an individual's life have turned to suicide may have an important bearing on the current situation.

Fourth, *inquire about changes in behavior.* Find out what different kinds of feelings and behavior have occurred in the recent past, and what kinds of depressed behavior or increases in activity level have been occurring. A person who seems to be recovering from a depression may be more dangerous than one who is still immobilized by depression, since the latter may not have the energy to make a serious suicide attempt.

Fifth, *evaluate the family background of the students.* Ask about recent separations or deaths. Is there a history of drug, alcohol, or child abuse? What is the family capacity to deal with the crisis the student is experiencing? A well-functioning family is an important resource for prevention or treatment; a poorly functioning one is a tremendous liability.

Sixth, *consider whether or not there have been precipitating events.* The most common precipitating event is a loss or threat of loss of a loved one. The existence of key events may help the special service worker to gauge the need for specific referral (e.g., an expert on grief).

Seventh, *probe for the existence of a support network.* Are there one or more interested persons involved who are willing to help the adolescent to stay alive? Beebe terms this a "lifeline" (1975). The presence of a lifeline can make the difference between a need for hospitalization and outpatient care.

Eighth, *evaluate the student's conception of death.* What does the adolescent understand about death? Does he or she have a concept of an afterlife?

Finally, *assess the individual's ego functioning.* How well is the young person able to assess reality and control

his impulses? The more disturbed the adolescent's coping mechanisms, the less likely he or she will be to deal constructively with the situation, and the more serious the problem.

All of these factors taken together allow the professional to decide how imminent the danger is to the student and how necessary it may be to have the adolescent hospitalized or in some other way involuntarily held for further evaluation. If the above process results in a decision that the situation is not immediately lethal, normal referrals may be made to mental health and medical professionals. If the referral is made only to the adolescent it should be accompanied by a contract to a "follow-up," e.g., a call from the agency or therapist the adolescent is referred to, to underline the importance of the referral and the concern of the referring person. If the adolescent refuses such a contract, a consultation with the school psychologist or the referring person's supervisor would be necessary. This position, unfortunately, is a very delicate one, clinically speaking, and a referral and perhaps further evaluation would be called for.

Peer Counseling Options

An ironic discovery is that fellow students are the most aware of who is suicidally at risk (Nelson, 1986). For this reason it may make sense to aim preventive intervention in the schools at all students, making them more aware of danger signs and more sophisticated about the dynamics of suicide. A further extension of this intervention would be to train some peer counselors in ways to facilitate referrals within the school setting and to help others who come to their attention.

Students themselves are aware of the potential that peer counseling approaches have for solving many school problems. In April 1985, for example, the Student Advisory Board on Education, a program of the California Association of Student Councils, recommended that the State Board of Education compile information on peer counseling programs, develop exemplary programs, and disseminate these findings to all secondary schools in the state to assist them in implementing their own programs. The Advisory Board pointed out that "peer counseling may have a significant positive impact on troubled students," especially in reducing the incidence of teenage suicide, dropout rates, drug use, pregnancy, drunk driving, and vandalism. Unfortunately, no peer counseling programs directed at suicide prevention have been documented in the literature.

Factors to consider in using peer counseling options for suicide prevention include the following: choice of grade level, training of peer counselors, qualifications of peer counselor trainers, organization of the program, the curriculum or course of study, kinds of problems to be handled, skills to be taught, roles of the peer counselors, curriculum materials and resources available, and the evaluation of program effectiveness.

School personnel planning to establish peer counseling or peer facilitator programs should keep in mind some of the cautions to be observed. The tendency of teenagers to turn to their peers in times of crisis may reflect the struggle with dependency characteristic of adolescence. Adults are often viewed—with apprehension—as more likely to interfere than understand. In contrast, peers are perceived as less likely to interfere, and more likely to empathize, and to keep a secret. The same qualities that make friends the confidants of choice also may make them dangerously inadequate as peer counselors. Adolescents' willingness to keep a confidence, their inability or disinclination to intervene actively, and their lack of knowledge about what could or should be done often make them silent partners in a youth suicide.

Peer counseling should not be expected to replace professional help. Rather, peer counselors should be facilitators. They need to be able to deal with their own fears, to include themselves in the discussions, to be sensitive to the feelings and values of others, and to remember at all times that they are essentially helpful friends, not therapists. Peer counselors should be taught—just like parents—to listen, to be honest, to share feelings, and to get help.

Consultation with Staff

Enabling school personnel, teachers, and principals to become more helpful in suicidal crises is an important consultative activity. Consultation can assist personnel to become more willing to discuss the subject and not be appalled or disgusted by it. With help, teachers and

administrators can open lines of communication with students so that they may talk about how they feel about suicide and depression. In addition, school people can be made aware of *how their activities such as publicly embarrassing students or emphasizing student failures and shortcomings, may help* create the sense of *helplessness* and hopelessness that play such a central role in suicidal behavior. Consultation may also show school personnel how to assist in suicidal crisis referrals. With assistance they can make better and earlier referrals to special services workers and to professionals outside of school.

Community resources are often available in local areas to serve school personnel as consultants to supplement school-based personnel. In many areas community professionals are invited regularly into the schools to meet with staff members, to explain to everyone involved how referrals may be made, and to describe what special resources or expertise particular agencies have at their disposal.

Research on Suicide Prevention

As suicide prevention activities become more and more common it will become increasingly necessary to evaluate the effectiveness of these programs through research efforts. Because the incidence of suicide is not high, it will take a long time to determine whether or not preventative activities are successful. It is anticipated that research will take a *case study approach*, at least initially, although curriculum approached will be evaluated by student's increased knowledge and sensitivity (e.g., Nelson, 1986). Answers are needed to such questions as: Which programs are most successful? What elements of the programs result in the greatest change in attitude on the part of the recipients? It will be interesting to learn if certain groups of students at risk respond differentially to treatments. Will aptitude-treatment interactions emerge in our preventative activities? For example, how successful are programs designed to prevent suicidal outcome from occurring in those students who are at risk because of the loss of a loved one? Perhaps programs focusing on students who have experienced losses can be fine tuned to the point where they may be more successful, say, than programs aimed at students who are at risk because of extreme guilt or emotional instability. Special services personnel in the school will obviously have an important research role to play in helping these relatively new programs of prevention become more successful in the years to come.

NOTE

1. Although outside the scope of this paper, parents may be helped too by (a) warning them to remove the means to suicide (guns, pills, etc.), (b) informing them about the time frame and course of depression, and (c) helping them avoid panic and helplessness.

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EMPIRICALLY SUPPORTED TREATMENTS

In an effort to improve the quality of treatment, the mental health field is promoting the use of empirically supported interventions. The following pages contain *excerpts* from a 1998 report entitled "Applying the Criteria for Empirically Supported Treatments to Studies of Psychosocial Interventions for Child and Adolescent Depression"by T. H. Ollendick and N. J. King, which appears in the *Journal of Clinical Child Psychology, 27*, 156-167.

Excerpted here are the abstract, the authors' conclusions, and their reference list.

Abstract of article by T. H. Ollendick and N. J. King, which appears in the *Journal of Clinical Child Psychology, 27*, 156-167.

Reviews the psychosocial treatment outcome studies for depressed children and adolescents and concludes that psychosocial interventions are effective at posttreatment and follow-up in reducing depressive symptoms/disorders in clinical and nonclinical samples of youth, regardless of treatment modality or extent of parental involvement. The article then examines the extent to which each study conforms to the guidelines set forth by the Task Force on Promotion and Dissemination of Psychological Procedures (1996) for well-established and probably efficacious interventions. Results of this analysis indicate only 2 series of studies that meet criteria for probably efficacious interventions and no studies that meet criteria for well-established treatments. Finally, the advantages and disadvantages of applying criteria for empirically supported treatments to identify good treatments for depressed youth are discussed, the importance of devising developmentally and culturally sensitive interventions targeted to the unique needs of each child is highlighted, and recommendations for future research that is informed by clinical practice and empirical findings are offered.

The following pages illustrate the gist of the article.

* * *

Criteria for Well-Established and Probably Efficacious Treatments

The following are the most recent criteria for ESTs (Chambless et al., 1996; see Lonigan et al., this issue). Because the child and adolescent depression intervention literature does not include a large series of single case design experiments, only criteria related to between-group design studies are delineated.

For an intervention to be deemed well established, there must be at least two good between-group design experiments demonstrating efficacy in one of the following ways: (a) superior to pill or psychological placebo or to another treatment, or (b) equivalent to an already established treatment in experiments with adequate statistical power ($n \geq 30$ per group). The experiments must be conducted in accordance with a treatment manual, sample characteristics must be detailed, and at least two different investigators or investigatory teams must demonstrate intervention effects. For an intervention to be classified as probably efficacious, either two experiments must demonstrate that the intervention is more effective than a wait-list condition or one or more experiments must meet all criteria for a well-established treatment, except for the requirement that treatment effects be shown by two different research teams...

...to date, none of the childhood depression intervention studies meet criteria for well-established treatments. The two studies conducted by Stark and colleagues (Stark et al., 1987, 1991), however, appear to meet criteria for probably efficacious treatments.

Because the investigations by Stark and colleagues represent the best available psychosocial treatment out-come studies for childhood depression, these studies are detailed. Stark et al. (1987) weighed the relative efficacy of 12-session group interventions involving self-control therapy, behavior problem-solving therapy, and a wait-list control for 29 fourth through sixth graders with elevated depression scores at two time points. The self-control intervention taught self-management skills (e.g., self-monitoring, self-evaluating, self-consequating, causal attributions). The behavioral problem-solving group intervention consisted of education, self-monitoring of pleasant events, and group problem solving directed toward improving social behavior. Postintervention within-group analyses found that participants in both active interventions reported fewer symptoms of depression and anxiety, whereas wait-list children reported minimal change. Between-group analyses revealed that children in the self-control condition showed relatively greater improvement in self-esteem and depressive symptoms, as measured by the Children's Depression Inventory (CDI; Kovacs, 1985), than the youth in the other two groups. However, no between-group differences were noted on the other measures of depression according to child or mother ratings or on measures of self-esteem or anxiety. At 8-week follow-up, 88% of the children in the self-control condition and 67% of the children in the behavioral problem-solving condition obtained CDI scores below the cutoff for depression (i.e., <13), and none of the participants in either experimental group met criteria for clinically significant levels of depressive symptoms according to their responses on the Children's Depression Rating Scale-Revised (CDRS-R; Poznanski, 1984). Also at follow-up, the children in the self-control condition reported greater generalization of treatment effects according to their responses to the CDRS-R and the Coopersmith Self-Esteem Inventory (Coopersmith, 1975), but no differences in depression levels were noted between the children in the self-control and behavioral problem-solving conditions on the CDI or the Child Depression Scale (Reynolds, 1989). Also, there were no between-group differences at follow-up in terms of mother's ratings of their child's depression on the Child Behavior Check-list (Achenbach & Edelbrock, 1983) or in terms of children's reports of anxiety. Taken together, results revealed that both experimental interventions were relatively successful in reducing symptoms of depression. For the most part, findings regarding the comparison of the self-control and behavioral problem-solving group interventions were equivocal. However, the pattern suggested that the self-control intervention was more beneficial to the children.

Based on results from the aforementioned study, Stark et al. (1991) evaluated an expanded version of self-control therapy for 26 fourth through seventh graders who endorsed high levels of depressive symptoms. This research offers only a partial replication of Stark's earlier work (i.e., Stark et al., 1987), as the self-control therapies tested in the two different treatment outcome studies were similar but not identical, and there was no behavioral problem-solving condition in the second study. The experimental intervention in the second study was a 24- to 26-session cognitive-behavioral treatment that consisted of self-control and social skills training, assertiveness training, relaxation training and imagery, and cognitive restructuring. This experimental treatment was compared to a traditional counseling condition designed to control for nonspecific elements of the intervention. Monthly family meetings for the cognitive-behavioral group encouraged parents to assist their children in applying their new skills and to increase the frequency of positive family activities. Monthly family sessions associated with the traditional counseling condition addressed improving communication and increasing pleasant family events. Postintervention and 7-month follow-up

assessments revealed decreases in self-reported depressive symptoms for both groups of children. At postintervention, youth in the cognitive-behavioral intervention reported fewer depressive symptoms on a semistructured interview and endorsed fewer depressive cognitions.

The 1987 and 1991 outcome studies by Stark and colleagues come the closest of all of the child studies to meeting the criteria for probably efficacious treatments. Specifically, client characteristics were specified, a treatment manual was used, and two adequate group design studies demonstrated that a self-control intervention was superior to a placebo treatment. However, as noted previously, the self-control interventions used in the two studies were not identical in terms of length of treatment or material covered. With these qualifications, we view this research program as approximating that required for being a probably efficacious EST.

* * *

... The intervention research conducted by Lewinsohn and coworkers (i.e., Lewinsohn et al., 1990; Lewinsohn et al., 1996) represents state-of-the-art adolescent depression intervention research. These methodologically sophisticated studies meet criteria for probably efficacious treatments as client characteristics were specified, a treatment manual was used. and two adequate group design studies demonstrated that a coping skills program was more efficacious than a wait-list condition. Thus, a brief description of these studies is warranted. In the first study, Lewinsohn et al. (1990) randomly assigned 59 high school students, ages 14 to 18 years who met diagnostic criteria for depressive disorders, to cognitive-behavioral group treatment for the adolescent only, concurrent cognitive-behavioral treatment groups for the depressed adolescent and his or her parents, and a wait-list control condition. The cognitive-behavioral intervention, based on the Coping With Depression (CWD) course for adults, was adapted to address the concerns and competencies of adolescents. The CWD, a 14-session multiple component intervention, focuses on experiential learning and skills training, with attention to increasing pleasant activities, training in relaxation, controlling depressive thoughts, improving social interaction, and developing conflict resolution skills. The seven-session complimentary parent intervention program is designed to enhance parents' ability to reinforce their adolescent's adaptive changes, which should increase the maintenance and generalization of treatment effects. Postintervention assessment indicated that fewer adolescents in the two active treatment groups met diagnostic criteria for depression as compared to youth in the wait-list group. Also, compared to their nontreated counterparts, adolescents in the CWD adolescent-only and the CWD for adolescent-and-parent evidenced greater reductions in self-reported depressive and anxious symptoms and maladaptive cognitions and evidenced more involvement in positive events. Treatment gains were maintained at 2-year follow-up. Although there were a few statistically significant differences between the adolescent-only CWD condition and the adolescent-and-parent CWD, no between-group differences were found on most variables, suggesting either that the outcome was similar for both groups or that with a larger sample, the adolescent-and-parent CWD would prove to be more effective than the adolescent-only condition.

The second study conducted by Lewinsohn et al. (1996) was a replication, with modifications, of the prior design. Skills training was interwoven throughout the CWD course rather than offered in single blocks in separate sessions. The other modification was the addition of random assignment to different conditions during the 2-year follow-up phase: (a) booster sessions plus assessment every 4 months, (b) assessment only every 4 months, and (c) annual assessment only. In a sample of 96 adolescents meeting diagnostic criteria for major depressive disorder or dysthymic disorder, recovery rates in the two active treatment conditions (i.e., CWD = 65%, CWD plus parent intervention = 69%) were greater than those for the adolescents in the wait-list control group (48%). No significant differences were found between the two experimental groups. Comparable recovery and relapse rates were reported for the three follow-up conditions. Of particular interest was that at the 2-year follow-up, 97.5% of adolescents who participated in an active treatment condition no longer met criteria for a depressive disorder.

Current Empirical Status of Psychosocial Interventions for Depressed Children and Adolescents

In summary, results from this review reveal that several psychosocial intervention programs, the majority of which are based on a cognitive-behavioral model, are effective in reducing depressive symptoms and alleviating depressive disorders in nonclinical samples of children and both clinical and nonclinical samples of adolescents. Positive treatment effects are noted regardless of treatment modality (group, individual. or family therapy) or nature or extent of parental involvement. Treatment effects generally are maintained at follow-up. However, because most of the studies were conducted in schools with nonreferred youth with depressive symptoms and used relatively inexperienced clinicians, the generalizability of the findings across populations, settings, and clinician-experience level remains unclear. Further, because few between-group design studies have compared different interventions, it is premature to conclude that any specific intervention approach is most

efficacious in reducing depression in youth. Given that the intervention literature on mood disorders in youth is in its infancy and most of the studies were conducted prior to the establishment of the criteria for ESTs, it is not surprising that none of the interventions met criteria for well-established treatments and only one series of child studies and one series of adolescent studies appear to meet the criteria for probably efficacious interventions.

Strengths and Weaknesses of the EST Approach

Our review of the child and adolescent depression treatment literature brings to the fore a number of advantages and disadvantages of the EST movement. There are enumerable methodological advantages to ascertaining the efficacy of an intervention based on its superiority to a pill, placebo, or other treatment or its equivalence to an already established treatment when a random assignment to control study is conducted. Only with random assignment can between-group differences in the reduction of depression and its sequelae be attributed to the intervention. However, a major clinical concern often emerges regarding random assignment to a placebo control condition. Some youth with significant problems (e.g., suicidal ideation) will not receive adequate and timely care in the control condition. Many researchers have handled this issue by eliminating children with elevated levels of suicidal ideation. This, however, limits the utility of the interventions to those depressed youth in greatest need.

The primary advantages of conducting treatments in accord with a manual are that such interventions (a) are systematic, focused, and goal-oriented; (b) enable more mental health professionals to be trained to provide effective psychosocial interventions for depressed youth; (c) increase our ability to detect differences between treatment conditions; and (d) have a greater likelihood for replication. A number of obstacles impede the use of treatment manuals for addressing child and adolescent depression. First, rigid application of a manualized treatment protocol may result in difficulty establishing rapport with a depressed youth and ineffective dissemination of psychological services due to the therapist's inability to attend to the distinctive mood or context of each session or the child's current concerns. Second, it is difficult for an intervention manual to address individual differences (e.g., depression symptoms and severity, comorbid conditions, education level, cognitive level, age, sex, family constellation, family income, attendance patterns). Third, most treatment manuals only address a singular problem (e.g., depression) rather than the comorbid psychological conditions and environmental influences (e.g.. poverty, physical/sexual abuse, parent and child substance abuse and psychiatric problems. parental cognitive limitations) that impact the child's adjustment and that often are of greater concern to the child or family than the child's depression. Finally, most treatment manuals lack systematic attention to the child's background (e.g., ethnicity, income level), belief system, and expectations of therapy.

The key advantage of specifying client characteristics is that this information is crucial to considerations regard-ing the generalizability of the findings. There are no disadvantages to informing the reader of the client character-istics. However, the issue of determining client characteristics for inclusion criteria often is a challenging one. Developing inclusion criteria comprehensive enough to promote participation of all youth who need the intervention results in considerable within-group variability. It is difficult to control for this variability when matching the experimental and control groups. Many researchers address this dilemma by providing relatively narrow inclusion criteria, which limits the generalizability of findings from research studies to actual clinical practice. Often treatment outcome researchers, in an effort to conduct methodologically sophisticated studies, place methodological rigor above clinical reality.

The merits of determining the efficacy of an intervention across research teams are without question, and there are no disadvantages of such a recommendation. The dilemma for researchers in achieving this goal is the limited research funding available for conducting psychosocial intervention studies for depressed youth.

A Look to the Future

In closing, a number of problems with the child and adolescent depression treatment literature are noteworthy and have implications for the development and implementation of future treatment outcome studies. First, most studies failed to accommodate developmental differences in children's competencies and did not assess the benefits of various intervention strategies for youth at different ages and developmental levels. The protocols often failed to incorporate the pertinent developmental psychology literature on cognitive and affective development, but rather appeared to be downward extensions of adult depression interventions. Thus, future research should integrate developmental research findings on the cognitive, affective, and social functioning of youth in devising and implementing therapies for depressed children and adolescents. Given that children are embedded within a family context, a developmental perspective also highlights the importance of active family involvement, including family therapy (Kaslow & Racusin, 1994).

A second problem is the lack of a culturally sensitive perspective. Most studies were conducted

with middle-class, Caucasian youth, and little attention was paid to the cultural relevance of the materials used, the intervention strategies incorporated, and the cultural background and sensitivity of the therapists who administer the protocols. Thus, in the future, researchers should include diverse groups of children, the therapists should be cognizant of the child's sociocultural context and aware of their own ethnicity affects the therapeutic alliance, and culturally sensitive assessment and interventions should be incorporated.

Third, there are no data that indicate which treatments are most effective for which depressed children and adolescents, and none of the investigatory teams have examined which specific component(s) of the multifaceted interventions is most beneficial for which children. Future studies would be more informative if they examined which children benefitted most from which intervention components (e.g., social skills training, cognitive restructuring, family involvement).

This would help clinicians to target specific intervention components for different children and families. In addition, researchers need to ascertain which depressed children are most likely to benefit from cognitive-behavioral versus interpersonal versus family therapy versus pharmacology, or some combination thereof. Such information will enable clinicians and clinical researchers to provide the optimal treatment for each depressed child or adolescent.

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PSYCHOTROPIC MEDICATIONS

This chart provides some brief information on psychotropic medications frequently prescribed for students. The medications are listed with respect to the diagnosis that leads to their prescription. For more information, see the *Physicians Desk Reference.*

Diagnosis: Bipolar Disorder

Medication Types and Treatment Effects

A. Anti-manic

Used to reduce frequency and intensity of manic episodes. Typical symptoms of mania include pressure of speech, motor hyperactivity, reduced need for sleep, flight of ideas, grandiosity, poor judgement, aggressiveness, and possibly hostility.

B. Anti-convulsant

Approved to treat various seizure types among those tat least 6 years of age. Carbamazepine is regarded as most beneficial for persons diagnosed with partial seizures with complex symptomatology (psychomotor or temporal lobe), but those with generalized tonic-clonic seizures or a mixed seizure pattern also may benefit (Green, 1995)

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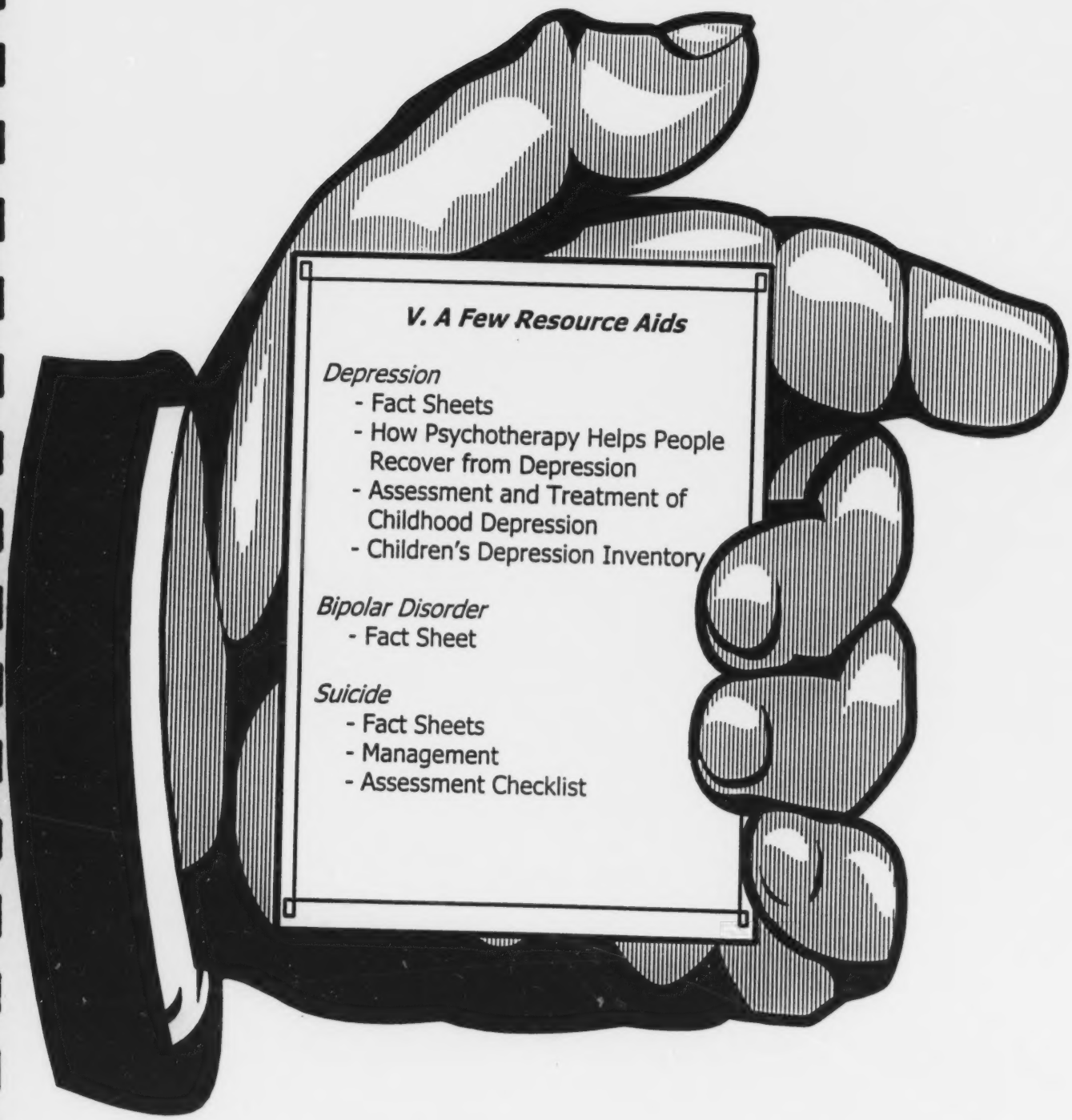
Names: Generic (Commercial)	**Some Side Effects and Related Considerations**
A. Anti-manic	
lithium carbonate/citrate [Lithium, Lithane, Lithobid, ithotabs, Lithonate, Eskalith Cibalith	Safety and effectiveness have not been established for those under 15 years of age. May manifest tremor, drowsiness, dizziness, nausea, vomiting, fatigue, irritability, clumsiness, slurred speech, diarrhea. increased thirst, excessive weight gain, acne, rash. Serum levels must be monitored carefully because of therapeutic dose is close to toxic level. Care must be taken to maintain normal fluid and salt levels.
B. Anti-convulsants	
Carbamazepine [Tegretol, Mazepine, Epitol]	May manifest drowsiness, dizziness, fatigue, coordination problems, respiratory depression, edema, nausea, vomiting, hepatitis, nystagmus, and various negative effects associated with trycyclic antidepressants. Parents are instructed to withhold and notify physician immediately if signs of toxicity (e.g., anorexia, fever, unusual fatigue, bruising, bleeding). Females using oral contraceptives are informed that reliability of contraceptive may be reduced.
Valproic acid [Depakene]	Most serious side effect is hepatic failure which can be fatal. It occurs most frequently within the first six months of treatment. Children under two years of age are at increased risk; the risk of hepatoxicity decreases considerably as patients become progressively older. Hence, liver function must be monitored carefully and frequently, especially during the first six months. Nausea, vomiting, and indigestion may occur early in treatment and usually are transient. Sedation may occur, and untoward psychiatric effects such as emotional upset, depression, psychosis, aggression, hyperactivity, and behavioral deterioration have been reported.


V. A Few Resource Aids
Depression
- Fact Sheets
- How Psychotherapy Helps People Recover from Depression
- Assessment and Treatment of Childhood Depression
- Children's Depression Inventory
Bipolar Disorder
- Fact Sheet
Suicide
- Fact Sheets
- Management
- Assessment Checklist

MAJOR DEPRESSION IN CHILDREN AND ADOLESCENTS

This is one of a series of fact sheets on the mental, emotional, and behavior disorders that can appear in childhood or adolescence The Center for Mental Health Services extends appreciation to the National Institute of Mental Health for contributing to the preparation of this fact sheet.

What is Depression?

Major depression is one of the mental, emotional, and behavior disorders that can appear during childhood and adolescence. This type of depression affects a young person's thoughts, feelings, behavior, and body. Major depression in children and adolescents is serious; it is more than "the blues". Depression can lead to school failure, alcohol or other drug use, and even suicide.

What Are the Signs of Depression?

Young people with depression may have a hard time coping with everyday activities and responsibilities, have difficulty getting along with others, and suffer from low self-esteem. Signs of depression often include:

- sadness that won't go away;
- hopelessness;
- loss of interset in usual activities;
- changes in eating or sleeping habits;
- missed school or poor school performance;
- aches and pains that don't gat better with treatment; and
- thoughts about death or suicide.

Some young children with this disorder may pretend to be sick, be overactive, cling to their parents and refuse to go to school, or worry that their parents may tie. Older children and adolescents with depression may sulk, refuse to participate in family and social activities, get into trouble at school, use alcohol or other drugs, or stop paying attention to their appearance. They may also become negative, restless, grouchy, aggressive, or feel that no one understands them. Adolescents with major depression are likely to identify themselves as depressed before their parents suspect a problem. The same may be true for children.

How Common is Depression?

Recent studies show that, at any given time, as many as 1 in every 33 children may have depression. The rate of depression among adolescents is closer to that of depression in adults, and may be as high as one in eight.*

Having a family history of depression, particularly a parent who had depression at an early age, increases the chances that a child or adolescent may develop depression. Once a young person has experienced a major depression, he or she is at risk of developing another depression within the next 5 years. This young person is also at risk for other mental health problems.

In this fact sheet, "Mental Health Problems" for children ant adolescents refers to the range of all diagnosable emotional, behavioral, and mental disorders. They include depression, attention-deficit/ hyperactivity disorder, and anxiety, conduct, and eating disorders, among others. Mental health problems affect one in every five young people at any given time.

"Serious Emotional Disturbances" for children and adolescents refers to the above disorders when they severely disrupt daily functioning in home, school, orcommunity. Serious emotional disturbances affect 1 in every 20 young people at any given time.

What Help is Available for a Young Person with Depression?

While several types of antidepressant medications can be effective to treat adults with depression, these medications may not be as effective in treating children and adolescents. Additional research is needed to determine whether antidepressants are useful in helping young people. Researchers also are concerned about potential severe side effects of these medications.

Some success has been reported recently with a drug called fluoxetine (Prozac). Fluoxetine seems to have fewer side effects than other antidepressant medications. However, care must be used in prescribing and monitoring all medication.

Many mental health care providers use counseling to help children and adolescents with depression. The National Institute of Mental Health has made it a priority to evaluate the effectiveness of individual counseling, family counseling, and group therapy.

A child or adolescent in need of treatment or services and his or her family may need a plan of care based on the severity and duration of symptoms. Optimally, this plan is developed with the family, service providers, and a service coordinator, who is referred to as a case manager. Whenever possible, the child or adolescent is involved in decisions.

In a "System of Care", local organizations wok in teams—with families as critical partners—to provide a full range of services to children and adolescents with serious emotional disturbances. The team strivest to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more infonnation on systems of care, call 1.800.789.2647.)

Tying together all the various supports and services in a plan of care for a particular child and family is commonly referred to as a "system of care." A system of care is designed to improve the child's ability *to* function in all areas of life—at home, at school, and in the community

What Can Parents Do?

If parents or other important adults in a child's or teenager's life suspect a problem with depression, they should:

- Make careful notes about the behaviors that concern them. Note how long the behaviors have been going on, how often they occur, and how severe they seem.
- Get an appointment with a mental health professional or the child's doctor for evaluation and diagnosis.
- Get accurate information from libraries, hotlines, or other sources.
- Ask questions about treatments and services.
- Talk to other families in their community.
- Find family network organizations.

It is important for people who are not satisfied with the mental health care they are receiving to discuss their concerns with the provider, to ask for information, andlor to seek help from other sources.

Important Messages About Children's and Adolessents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is availableVor free publications, references, and referrals to local and national resources and organizationsHall 1.800.789.2647; STY 301.443.9006; http://www.mentalhealth.org/

These estimates provide only a rough gauge of the prevalence rates (number of existing cases in a defined time period) for this disorder. The National Institute of Mental Health is currently engaged in a nationwide study to determine with greater accuracy the Prevalence of mental disorders among children and adolescents. This information is needed to increase understanding of mental health problems and to improve the treatments and services that help young people who are affected by these conditions.

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administeration - Center for Mental Health Services
5600 Fishers Lane, Room 13-103 Rockville, Maryland 20857 Tel: (301)443-2792
For information about children's mental health contact the CMHS Knowledge Exchange Network
PO Box 42490 Washington, DC 20015 tel: 1-800-789-2647 fax: (301)984-8796 TTY: (301)443-9006
CMHS Electronic Bullitin Board 1-800-790-2647

DEPRESSION IN CHILDHOOD

Description/Symptoms/Diagnosis

Depression is a type of mood disorder with a variety of symptoms that may vary depending on the age of the child. In many ways the disorder is similar to depression in adulthood in that children may look sad, express hopelessness, lose interest in their usual activities, sleep more or less than usual, have a poor appetite, and express a feeling of tiredness. In younger children, however, some of the symptoms may be different. For example, they may cling to their parents, refuse to go to school, or express exaggerated fears of their parents' death. In adolescents, symptoms of depression manifest themselves in yet other ways such as sulkiness, refusal to cooperate in family and social activities, school problems and perhaps abuse of drugs or alcohol Older children with depression become restless, grouchy, or aggressive.

Depression may occur as a single episode, be recurrent, or accompany a manic episode as in a bipolar disorder (formerly called manic-depressive disorder). Problems in diagnosing depression in childhood are related to developmental stages of formals childhood. It is sometimes difficult to know whether children are just going through a stage of development, such as the "terrible twos" or "turbulent adolescence", or if they truly are depressed. Episodes of low moods when things go wrong are just as common among children as they are among adults; these are sometimes referred to as reactive depressions. Childhood depression may be unrecognized or misdiagnosed when symptoms arc mixed with other behaviors such as hyperactivity or delinquency.

Causation/Incidence

Most mental health professionals now agree that depression, including childhood depression, has an organic basis. This means that depression is rooted in a person's chemical makeup which is largely determined by genetics. Studies show that depression runs extensively through some famines and not others. It is also widely acknowledged that very stressful events can trigger any of the above types of depression. If a person's body chemistry is genetically linked to depressions it may take relatively little to trigger a depressive episode. Tests are being investigated which may show how chemical balance is disrupted during depressive episodes.

Feelings of sadness and increased emotional intensity are common among children and adolescents. However, only 10 to 12 percent of ten-year-olds of these children are severely depressed and have symptoms in need of treatment. Depression increases sharply in adolescence. Some surveys have indicated that symptoms of depression may occur in as many as 40 percent of teenagers. Depressive disorders in childhood are more common among boys whereas in adolescence such disorders are more common among girls. Suicide and substance abuse can be complications of depression. Adolescents attempt or commit suicide far more often than children do. Suicide is rare in children under twelve years of age.

Treatment

Untreated depression may lead to subsequent problems in adulthood. Also because of the possibilities of suicide in adolescence, early detection and treatment of childhood depression is imperative. Medications, such as antidepressants or lithium, can be an important part of treatment of depression in children and adolescents, just as it is with adults. However, research with children suggests that medications alone may not completely address all the symptoms of the child with depression. Some children also may have problems with social skills and other areas of social functioning and may benefit from other types of treatment such as individual, group, family therapy, or behavioral therapy.

Role of Family/Impact on Family

Life with a child who has a serious emotional disorder may be associated with a number of troubling and conflicting feelings love. anger, anxiety, grief, guilt, fear, and depression. These feelings are not unusual; most parents find it is helpful to share these feelings with someone else--family, friends, a support group, or some other informal group. Parents need to realize the scope and limitations of their responsibility and learn to take care of themselves as well as their child. Professional help in the form of individual, couples, or family counseling may be helpful in providing emotional support and guidance and help in the child's's recovery.

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October 1990

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National Mental Health Association

Childhood Depression Fact Sheet

What Is Depression?

Clinical depression goes beyond sadness. It's not having a bad day. Or coping with a major loss, such as the death of a parent, grandparent or even a favorite pet. It's not a personal weakness or a character flaw. Children suffering from clinical depression cannot simply "snap out of it."

Depression is a form of mental illness that affects the whole person - it impacts the way one feels, thinks and acts. Depression in children can lead to school failure, alcohol or other drug use, and even suicide.

Know The Signs.

- Persistent sadness and hopelessness
- Withdrawal from friends and activities once enjoyed
- Increased irritability or agitation
- Missed school or poor school performance
- Changes in eating and sleeping habits
- Indecision, lack of concentration or forgetfulness
- Poor self-esteem or guilt
- Frequent physical complaints, such as headaches and stomachaches
- Lack of enthusiasm, low energy or motivation
- Drug and/or alcohol abuse
- Thoughts of death or suicide

Know The Facts.

As many as one in every 33 children and one in eight adolescents may have depression. (U.S. Center for Mental Health Services (CMHS), 1996) Once a young person has experienced a major depression, he or she is at risk of developing another depression within the next five years. (CMHS, 1996) Two-thirds of children with mental health problems do not get the help they need. (CMHS, 1996) A recent study led by Dr. Graham Emslie of the University of Texas Southwestern Medical Center concludes that treatment of major depression is as effective for children as it is for adults. (American Medical Association, *Archives of General Psychiatry,*

November 15, 1997) Suicide is the third leading cause of death for 15 to 24 year olds (approximately 5,000 young people) and the sixth leading cause of death for five to 15 year olds. (American Academy of Child & Adolescent Psychiatry (AACAP), 1995.) The rate of suicide for five to 24 year olds has nearly tripled since 1960, making it the leading cause of death in adolescents and the second leading cause of death among college age youth. (AACAP, 1995)

Be Aware of Coexisting Disorders.

- Children under stress, who experience loss, or who have attention, learning or conduct disorders are at a higher risk for depression. (AACAP, 1995)
- Almost one-third of six to twelve year old children diagnosed with major depression will develop bipolar disorders within a few years. (AACAP, 1995)
- Four out of every five runaway youth suffer from depression. (U.S. Select Committee on Children, Youth & Families)
- Clinical depression can contribute to eating disorders. On the other hand, an eating disorder can lead to a state of clinical depression. (Stellefson, Medical University of South Carolina, 1998)

What Can Parents/Adults Do?

If parents/adults in a young person's life suspect a problem with depression, they should:

- Be aware of the behaviors that concern them and note how long the behaviors have been going on, how often and how severe they seem.
- See a mental health professional or the child's doctor for evaluation and diagnosis.
- Get accurate information from libraries, hotlines and other sources.
- Ask questions about treatments and services.
- Talk to other families in their community.
- Find family network organizations.

It is important for people who have questions about, or are not satisfied with, the mental health care they are receiving to discuss their concerns with the provider, ask for more information and seek help from other sources.

Help is Available.

Early diagnosis and treatment are essential for children with depression. Children who exhibit symptoms of depression should be referred to, and further evaluated by, a mental health professional who specializes in treating depression in children and teenagers. The diagnostic evaluation may include psychological testing, laboratory tests and consultation with other medical specialists. The comprehensive treatment plan may include medical psychotherapy, ongoing evaluations and monitoring, and in some cases, psychiatric medication. Optimally, this plan is developed with the family, and whenever possible, the child or adolescent is involved in the decisions.

This fact sheet was taken from: Childhood Depression Awareness Day, May 6, 1998. Planning Guide: What's the Matter?

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AMERICAN PSYCHOLOGICAL ASSOCIATION

How Psychotherapy Helps People Recover From Depression

According to the National Institute of Mental Health, an estimated 17 million adult Americans suffer from depression during any one-year period. Many do not even recognize that they have a condition that can be treated very effectively. This question-and-answer fact sheet discusses depression with a focus on the ways in which psychotherapy can help a depressed person recover.

How does depression differ from occasional sadness?

Everyone feels sad or 'blue' on occasion. Most people grieve over upsetting life experiences such as a major illness, loss of job, a death in the family or divorce. These feelings of grief tend to become less intense on their own as time goes on.

Depression occurs when feelings of extreme sadness or despair last for at least two weeks or longer and when they interfere with activities of daily living – such as working, or even eating and sleeping. Depressed individuals tend to feel helpless and hopeless and to blame themselves for having these feelings. Some may have thoughts of death or suicide.

People who are depressed may become overwhelmed and exhausted and stop participating in certain everyday activities altogether. They may withdraw from family and friends.

What causes depression?

Changes in the body's chemistry influence mood and thought processes, and biological factors contribute to some cases of depression. In addition, chronic and serious illness such as heart disease or cancer may be accompanied by depression. With many individuals, however, depression signals first and foremost that certain mental and emotional aspects of a person's life are out of balance.

Significant transitions and major life stressors such as the death of a loved one or the loss of a job can help bring about depression. Other more subtle factors that lead to a loss of identity or self-esteem may also contribute. The causes of depression are not always immediately apparent, so the disorder requires careful evaluation and diagnosis by a trained mental health care professional.

Sometimes the circumstances involved in depression are ones over which an individual has little or no control. At other times, however, depression occurs when people are unable to see that they actually have choices and can bring about change in their lives.

Can depression be treated successfully?

Absolutely. Depression is highly treatable when an individual receives competent care. Psychologists are among the licensed and highly trained mental health providers with years of experience studying depression and helping patients recover from it.

There is still some stigma, or reluctance, associated with seeking help for emotional and mental problems, including depression. Unfortunately, feelings of depression often are viewed as a sign of weakness rather than as a signal that something is out of balance. The fact is that people with depression can not simply 'snap out of it' and feel better spontaneously.

Persons with depression who do not seek help suffer needlessly. Unexpressed feelings and concerns accompanied by a sense of isolation can worsen a depression. The importance of obtaining quality professional health care can not be overemphasized.

How does psychotherapy help people recover from depression?

There are several approaches to psychotherapy – including cognitive-behavioral, interpersonal, psychodynamic and other kinds of 'talk therapy' – that help depressed individuals recover. Psychotherapy offers people the opportunity to identify the factors that contribute to their depression and to deal effectively with the

psychological, behavioral, interpersonal and situational causes. Skilled therapists such as licensed psychologists can work with depressed individuals to:

- pinpoint the life problems that contribute to their depression, and help them understand which aspects of those problems they may be able to solve or improve. A trained therapist can help depressed patients identify options for the future and set realistic goals that enable these individuals to enhance their mental and emotional well-being. Therapists also help individuals identify how they have successfully dealt with similar feelings, if they have been depressed in the past.
- Identify negative or distorted thinking patterns that contribute to feelings of hopelessness and helplessness that accompany depression. For example, depressed individuals may tend to overgeneralize, that is, to think of circumstances in terms of 'always' or 'never.' They may also take events personally. A trained and competent therapist can help nurture a more positive outlook on.
- Explore other learned thoughts and behaviors that create problems and contribute to depression. For example, therapists can help depressed individuals understand and improve patterns of interacting with other people that contribute to their depression.
- Help people regain a sense of control and pleasure in life. Psychotherapy helps people see choices as well as gradually incorporate enjoyable, fulfilling activities back into their lives.

Having one episode of depression greatly increases the risk of having another episode. There is some evidence that ongoing psychotherapy may lessen the chance of future episodes or reduce their intensity. Through therapy, people can learn skills to avoid unnecessary suffering from later bouts of depression.

In what other ways do therapists help depressed individuals and their loved ones?

The support and involvement of family and friends can play a crucial role in helping someone who is depressed. Individuals in the 'support system' can help by encouraging a depressed loved one to stick with treatment and to practice the coping techniques and problem-solving skills he or she is learning through psychotherapy.

Living with a depressed person can be very difficult and stressful on family members and friends. The pain of watching a loved one suffer from depression can bring about feelings of helplessness and loss. Family or marital therapy may be beneficial in bringing together all the individuals affected by depression and helping them learn effective ways to cope together. This type of psychotherapy can also provide a good opportunity for individuals who have never experienced depression themselves to learn more about it and to identify constructive ways of supporting a loved one who is suffering from depression.

Are medications useful for treating depression?

Medications can be very helpful for reducing the symptoms of depression in some people, particularly for cases of moderate to severe depression. Some health care providers treating depression may favor using a combination of psychotherapy and medications. Given the side effects, any use of medication requires close monitoring by the physician who prescribes the drugs.

Some depressed individuals may prefer psychotherapy to the use of medications, especially if their depression is not severe. By conducting a thorough assessment, a licensed and trained mental health professional can help make recommendations about an effective course of treatment for an individual's depression.

Depression can seriously impair a person's ability to function in everyday situations. But the prospects for recovery for depressed individuals who seek appropriate professional care are very good. By working with a qualified and experienced therapist, those suffering from depression can help regain control of their lives.

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Also available online at:
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Assessment and Treatment of Childhood Depression

From the Clinical Child Psychology Newsletter, Volume 13, Number 3; Fall 1998
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✦Definition and Prevalence of Unipolar Depression

For a child to receive a DSM-IV diagnosis of major depressive disorder, the child's symptoms must cause impairment of daily functioning, reflect a change from baseline, and may not be secondary to uncomplicated bereavement. The child must exhibit at least five of the following symptoms during the same two week period: (1) depressed or irritable mood (must be present for diagnosis); (2) anhedonia; (3) decreased weight or appetite or failure to make expected weight gains; (4) sleep disturbance; (5) psychomotor agitation or retardation; (6) fatigue or loss of energy; (7) feelings of worthlessness or inappropriate guilt; (8) concentration difficulties or indecisiveness; and (9) thoughts of death and/or suicide. Other depressive disorders that may be manifested in youth include dysthymic disorder and adjustment disorder with depressed mood. While the DSM-IV acknowledges the existence of depressive disorders in youth, DSM-IV criteria for mood disorders lack a developmental perspective, failing to account for children's cognitive, affective, and interpersonal competencies, and biological maturation (Cicchetti & Schneider-Rosen, 1986). As a result, the criteria for the diagnosis for children are almost identical to those for adults. Dissatisfaction with these criteria have led many to advocate for a develop-mental psychopathology perspective with regard to the diagnosis of mood disorders in youth (Cicchetti & Schneider-Rosen, 1986).

No large scale epidemiological study has been conducted regarding the incidence and prevalence of mood disorders in youth. The available data, however, reveal prevalence rates ranging from 2-5% in community samples and 10-50% in psychiatric settings (Fleming & Offord, 1990; McCracken, 1992; Petersen et al., 1993). Prevalence rates for mood disorders increase with age (Fleming & Offord, 1990). Although there is no evidence of con-sistent sex differences in depression rates among pre-pubertal youth, by age 15, females are twice as likely as males to receive a depressive diagnosis (Angold, 1988; Nolen-Hoeksema & Girgus, 1994).

✦Etiology

Multiple etiological models have been offered as explanations for depression in youth. The most commonly cited psychosocial models have emerged from psychodynamic, cognitive behavioral, and family systems theories.

Psychodynamic Perspective

Ego-analytic, object relations, and attachment theories offer the predominant current psychodynamic models of childhood depression. The ego-analytic model suggests that children with separation-individuation difficulties, and unrealistic expectations of them-selves and others are at increased risk for depression (Sandler &Joffee, 1965). Based on this model, depressed children's cognitive distortions reflect problematic parent-child interactions that produce low self-esteem, a perceived lack of instrumentality, dependence on others for gratification, and a negative frame of ref-erence that often renders them unhappy (Bemporad, 1994). According to object relations and attachment theories, early disruptions in attachment predispose individuals to symptoms associated with depression such as the experience of emptiness, helplessness, and a negative perception of the world (Bowlby, 1981). Little research has been conducted to assess the validity of the psychodynamic perspectives on mood disorders in youth.

Cognitive-Behavioral Perspective

Researchers have extensively studied the cognitions of depressed children and adolescents. This research reveals that the cognitive patterns of depressed children are similar to their adult counterparts. Specifically, compared to nondepressed children, depressed youth have impaired information-processing; cognitive distortions; a negative view of them-selves (low self-esteem), the world, and the future (hope-lessness); a perception of themselves as helpless and unable to control the events in their lives; a depressogenic attributional style (attribute negative life events to more internal, stable, and global causes and positive events to more external, unstable, and specific causes); and deficits in self-monitoring, self-evaluation, and self-reinforcement (Kaslow, Brown, & Mee, 1994). Despite the proliferation of research highlighting the cognitive deficits of depressed youth, the role of the negative cognitive style in the etiology of depression is only now beginning to be studied (Garber &

Hilsman, 1992).

Family Systems Perspective

Depressed youth typically have a familial history of psychopathology, particularly mood and substance use disorders (Hammen, 1991). In addition, these children are often from families with a history of several negative life events; experiences with high levels of negative life events place a child or adolescent at risk for depression (for reviews see Compas, Grant, & Ey, 1994; Garber &Hilsman, 1992). The families of depressed youth typically are characterized by the following relational pat-terns: attachment problems (e.g., insecure attachment), low cohesion, low support, child maltreatment, inappropriate levels of family control, high levels of family conflict, ineffective conflict resolution, difficulties with affect regulation, impaired communication patterns, transmission of depressive cognitions, and a poorness of fit between the child's temperament and the family's style of relating (Kaslow, Deering, & Ash, 1996; Kaslow, Deering, & Racusin, 1994). Little effort has been made to date to examine empirically the role of family dysfunction in the etiology of depressive disorders in youth.

✦Assessment

Psychosocial Approach

A psychosocial assessment of childhood depression uses a multi-trait, multi-method, multi-informant approach to examine individual and contextual factors. This method of assessment enhances diagnostic reliability and validity, addresses inter-informant discrepancies, and portrays youngsters' impairments and competencies across domains (e.g., cognitive, affective, and interpersonal functioning, adaptive behavior, negative life events) and settings. In brief, a thorough evaluation examines domains of functioning beyond mood related symptoms. Furthermore, a psychosocial evaluation involves interviews with the depressed child and primary caretakers and family members, completion of behavior ratings scales by multiple informants (e.g., child, parents, teachers, peers, clinicians), and when indicated, results from psychological testing. Given the potential contribution of family process, it can be valuable to assess interactional patterns.

Semi-structured Interviews

Hodges (1994) suggests that diagnostic interviews are optimal assessment tools for the diagnosis of clinical depression as a syndrome, while symptom checklists and questionnaires yield information about individual symptoms and psychological distress. Semistructured diagnostic clinical interviews include the Diagnostic Interview Schedule for Children, the Child Assessment Scale, the Schedule for Affective Disorders and Schizophrenia in School-Age Children, theDiagnostic Interview for Children and Adolescents, and the comorbid disorders also can be diagnosed through the use of these semi-structured diagnostic clinical interviews. This standardized method of assessment facilitates differential diagnosis.

Self-report questionnaires

Self-report questionnaires are the most commonly used assessment tool for the determination of the severity of depressive symptoms. Reliable and valid self-report measures that are appropriate for children ages eight and older include: Children's Depression Inventory, Reynolds Child Depression Scale, Reynolds Adolescent Depression Scale, Depression Self-Rating Scale, Children's Depression Scale, Beck Depression Inventory, and the Center for Epidemiological Studies Depression Scale (for review, see Reynolds, 1994). Self-report measures are preferred over diagnostic clinical inter-views because they are less lengthy, therefore they require less time to administer. However, self-report questionnaires should be used in conjunction with clinical interviews that offer a more comprehensive diagnostic picture of the level of psychological distressed experienced by the patient or client (Reynolds, 1994).

Medical Approach

Alcohol and illicit drugs as well as prescribed medication such as anticonvulsants, corticosteroids, and some antibiotics have depressive side-effects, therefore medical work-ups are helpful in ruling out depression due to organic causes. Medical work-ups should include a physical examination, a drug screen for the most commonly abused substances, and the gathering of information pertaining to familial history of depression. A lab-oratory work-up is also recommended in order to rule out infection, anemia, thyroid disease, parathyroid disease, kidney disorders, adrenal dysfunction and metabolic abnormalities, all of which are associated with depresion.

✦Treatment

Both psychosocial and psychopharmacological treatments are used with depressed children and adolescents. Although multiple treatment approaches have been advanced, few have been adequately evaluated (see Kaslow &Thompson, 1998 for review). The following section offers a brief overview of treatments with sound empirical support.

Empirically supported psychosocial interventions for children.

Multi-component treatments formulated from a cognitiv -behavioral perspective, consisting of less than 20 sessions, and admi-istered in group-format within a school setting have received the most consistent empirical support. These interventions (Stark, Reynolds, & Kaslow, 1987; Stark, Rouse, & Livingston, 1991) tend to consist of psychoeducational and cognitive-behavioral treatments that do not differ markedly from those that are commonly administered to adult populations. Treatment components involve enhancing skills in cognitive restructuring, problem-solving, relaxation, self-control, social skills, and social competence among depressed youth (for review see

Kaslow &Thompson, 1998).

Empirically supported psychosocial interventions for adolescents.

Similar to the psychosocial interventions for depression among children, most adolescent interventions consist of less than 20 sessions and are administered in a psychoeducational and group format. One well-designed adolescent intervention study, conducted by Lewinsohn, Clarke, Rohde, Hops, & Seeley (1996), suggests that cognitive-behavioral treatment is more effective at decreasing depressive symptoms among adolescents than a wait-list control condition. The cognitive-behavior intervention focused on increasing pleasant activities and enhancing skills in social competence, relaxation, con-flict resolution, and control-ling depressive thoughts. Lewinsohn and colleagues (1996) also found that cog-nitive behavioral treatment is equally effective in ameliorating depressive symptoms among adolescents when administered only to the adolescent in a group setting and when offered to the adolescent in a group setting combined with separate sessions for the parents.

Biological Interventions Pharmacotherapy.

Tricyclic antidepressants (TCAs) and specific sero-tonin reuptake inhibitors (SSRIs) are the most fre-

quently prescribed antidepressants. Monoamine oxidase inhibitors (MAOIs) are not recommended for children and adolescents due to their level of lethality in overdose and stringent dietary restrictions (Ryan, 1992).

Research has yielded mixed results regarding the efficacy of tricyclic antidepressants (TCAs) and specific serotonin reuptake inhibitors (SSRIs) in depressed children and adolescents. For example, open trial studies of TCAs, such as imipramine, amitriptyline, and nortriptyline, indicate that TCAs are effective in decreasing depressive symp-toms among prepubertal youth (for review, see Harrington, 1993).

Similarly, open-trial studies of SSRIs, such as fluoxetine (prozac) and fluvoxamine (luvox), indicate that these medications are effective in decreasing depressive symp-toms in adolescents (Harrington, 1993). However, double-blind studies do not support previous findings; TCAs (e.g. Geller, Fox, & Clark, 1994) and SSRIs (e.g., Apter, Ratzoni, King, Weizman, Iancu, Binder, & Riddle, 1994; Boulous, Kutcher, Gardner, &Young, 1992) have yielded similar results to placebo treatments.

While more method-ologically sound pharmaco-logical studies are needed to clarify the efficacy of antidepressants with various age groups, both TCAs and SSRIs are frequently used by child psychiatrists and pediatricians. While SSRIs are less lethal than TCAs in overdose and cause fewer harmful side effects, TCAs are less expensive and therefore more accessible to low-income youth (Rosenberg, Holttum, & Gershon, 1994).

✦Prevention

Prevention trials for depression are recent, although a number of pro-grams designed for youth fol-lowing stressful events (e.g., divorce, death of a family member) have implications for preventing depression. Similar to childhood and adolescent depression interventions, in the area of the prevention of depression among youth, the most effective prevention programs have been psychoeducational. For example, in one of the most effective programs, con-ducted by Jaycox, Reivich, Gillham, and Seligman (1994), it was found that 10-to 13-year-olds who received didactic training focusing on social problem solving, cognitive restructuring, assertiveness, negotiation, and coping strategies reported fewer depressive symptoms at six-month and two-year follow-up than their waitlist control counterparts. Similarly, Hains and Ellmann (1994) reported that those adole-cents who had received cognitive restructuring, problem solving, and coping skills training reported fewer depressive symptoms than a wait-list control group at follow-up. More recently, Clarke and colleagues (1995) compared a 15 session group cognitive prevention program and a treatment-as-usual condition for adolescents with self-reported depressive symptoms who did not meet diagnostic crite-ria for a mood disorder. A survival analysis indicated that at 12-month follow-up, adolescents in the experi-mental group were less likely than controls to meet the diagnostic criteria for a mood disorder. These findings su-port the utility of prevention programs in reducing the risk for mood disorders in at-risk youth.

Related psychoeductional prevention efforts focus on children of depressed parents. Beardslee and colleagues (e.g., Beardslee, & MacMillan, 1993; Beardslee et al, 1993) found that families in a clinician-based format were more positive about the program and developed more adaptive attitudes and behaviors for coping with stress than did families in the lecture-based program. These changes may be associated with improved parental management of high-risk children and more adaptive child coping, both of which may decrease the child's risk for depression.

✦Concluding Comments

Despite the proliferation of research on child and ado-lescent depression, research on effective treatments is only beginning to emerge. Initial results suggest that multi-component interventions guided by cognitive-behavioral principles produce sinificant reductions in depressive symptoms among children and adolescents. Other interventions may be effective, for example, family-based treatments, but few have received systematic empirical evaluation. Thus, given multiple etiologies among children and adoles-cents with depressive symptoms, it is premature to conclude that a single approach, or specific treatment compo-nent, will be uniformly effective across cases. Progress in this area will hinge on longitudinal investigations with an explicit developmental focus that consider the cognitive, interpersonal, and neurobiological processes associated with depressive risk and course. Such research will provide the basis for the

development and empirical validation of new interventions that aim to prevent or resolve depressive disorders.

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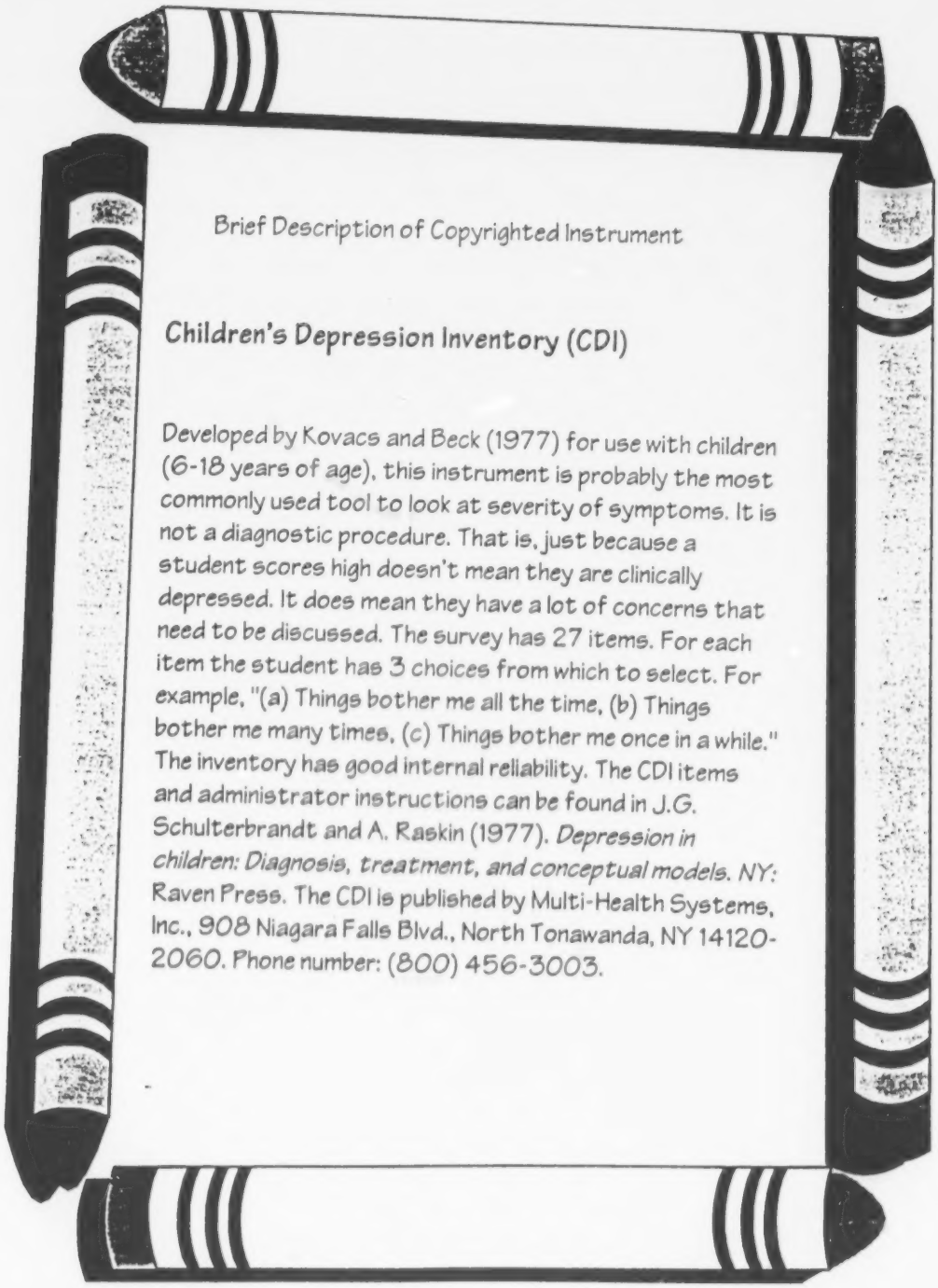

Brief Description of Copyrighted Instrument

Children's Depression Inventory (CDI)

Developed by Kovacs and Beck (1977) for use with children (6-18 years of age), this instrument is probably the most commonly used tool to look at severity of symptoms. It is not a diagnostic procedure. That is, just because a student scores high doesn't mean they are clinically depressed. It does mean they have a lot of concerns that need to be discussed. The survey has 27 items. For each item the student has 3 choices from which to select. For example, "(a) Things bother me all the time, (b) Things bother me many times, (c) Things bother me once in a while." The inventory has good internal reliability. The CDI items and administrator instructions can be found in J.G. Schulterbrandt and A. Raskin (1977). *Depression in children: Diagnosis, treatment, and conceptual models. NY:* Raven Press. The CDI is published by Multi-Health Systems, Inc., 908 Niagara Falls Blvd., North Tonawanda, NY 14120-2060. Phone number: (800) 456-3003.

NAMI
National Alliance for the Mentally Ill

Facts About Childhood-Onset Bipolar Disorder

Excerpts from the NAMI newsletter **Because Kids Grow Up**, Winter 1999

What is childhood-onset bipolar disorder (COBPD), and how does it differ from bipolar disorder (manic-depression) in adults?
All those with bipolar disorder experience mood swings that alternate from periods of severe highs (mania) to severe lows (depression). However, while these abnormally intense moods usually last for weeks or months in adults with the illness, children with bipolar disorder can experience such rapid mood swings that they commonly cycle many times within a day. ...

One of the most important factors in establishing the diagnosis is family history. According to several recent studies, a history of mood disorders (particularly bipolar disorder) and/or alcoholism on both the maternal and paternal sides of a family appears to be commonly associated with COBPD. ...

Many parents report that their children have seemed different since early infancy. They describe difficulty settling their babies, and note that their children are easily over-responsive to sensory stimulation. Sleep disturbances and night terrors are also commonly reported.

Later in a child's development, hyperactivity, fidgetiness, difficulties making changes, and high levels of anxiety (particularly in response to separation from the child's mother) are commonly seen. Additionally, being easily frustrated, having difficulty controlling anger, and impulsiveness (difficulty waiting one's turn, interrupting others) often result in prolonged and violent temper tantrums. ...

Rarely does bipolar disorder in children occur by itself. Rather, it is often accompanied by clusters of symptoms that, when observed at certain points of the child's life, suggest other psychiatric disorders such as attention-deficit/hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD), oppositional defiant disorder, and conduct disorder.

An estimated 50 percent to 80 percent of those with COBPD have ADHD as a co-occuring diagnosis. Since stimulant medications often prescribed for ADHD (Dexedrine, Adderall, Ritalin, Cylert) have been known to escalate the mood and behavioral fluctuations in those with COBPD, it is important to address the bipolar disorder before the attention-deficit disorder in such cases. Some clinicians suggest that the prescription of a stimulant for a child genetically predisposed to develop bipolar disorder may induce an earlier onset or negatively influence the cycling pattern of the illness. ...

The first line of treatment is to stabilize the child's mood and to treat sleep disturbances and psychotic symptoms if present. Once the child is stable, therapy that helps him or her understand the nature of the illness and how it affects his or her emotions and behavior is a critical component of a comprehensive treatment plan.

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Some medications have also proved useful. Since few treatment studies have been conducted in children, though, most clinicians use drugs that have been tested and proved successful in adult forms of bipolar disorder. For mood stabilization these include: lithium carbonate (Lithobid, Lithane, Eskalith), divalproex sodium (Depakote, Depakene), and carbamazepine (Tegretol). Newer agents such as gabapentin (Neurontin), lamotrigine (Lamictal), and topirimate (Topomax) are currently under clinical investigation and are being used in children. (Lamictal is not recommended for those under the age of 16.)

For the treatment of psychotic symptoms and aggressive behavior, risperidone (Risperdal) and olanzapine (Zyprexa) are commonly used newer agents, while thioridazine (Mellaril), trifluperazine (Trilafon), and haloperidol (Haldol) are old standbys. Clonazepam (Klonopin) and lorezapam (Ativan) are also used to treat anxiety states, induce sleep, and put a brake on rapid-cycling swings in activity and energy.

What about the use of antidepressant drugs?
It's very risky. Several studies have reported very high rates of the induction of mania or hypomania (rapid-cycling) in children with bipolar disorder who are exposed to antidepressant drugs of all classes. In addition, the child may experience a marked increase in irritability and aggression. The course of the disorder may be altered if antidepressants are prescribed without mood stabilizers.

Resources:
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Reviewed by Demitri F. Papolos, M.D., associate professor of psychiatry and co-director of the Program in Behavioral Genetics, Albert Einstein College of Medicine/Montefiore Medical Center, New York City

This fact sheet is available on-line:
http://www.nami.org/helpline/bipolar-child.html

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TEEN SUICIDE

Facts for Families from the American Academy of Child and Adolescent Psyciatry
3615 Wisconsin Ave. NW, Washington, D.C. 20016 (202)966-7300
Vol. 1. No. 10

Suicides among young people nationwide have increased dramatically in recent year. In 1984 more than 5,000 teenagers committed suicide, and experts estimate that the figure may be closer to 6,000. Today suicide is the third leading cause of death for teenagers, and the second leading cause of death for college students.

Many teenagers experience strong feelings of stress, confusion and self-doubt in the process of growing up, and the pressures to succeed combined with economic uncertainties and fears about nuclear war can intensify these feelings.

For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, or moving to a new community can be very unsettling and can intensify self-doubts. In some cases suicide appears to be a "solution."

Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnosed, and appropriate treatment plans should be made. When parents are in doubt whether their child has a serious problem, a psychiatric examination does no harm to the youngster.

Many of the symptoms of suicidal feelings are similar to those of depression. Parents should be aware of the following warning signs of adolescents who may try to kill themselves. Child psychiatrists recommend that if one or more of these signs occurs, parents should talk to their child about their concerns and seek professional help if the concerns persist.

- Change in eating and sleeping habits.
- Withdrawal from friends and family and from regular activities.
- Violent or rebellious behavior, or running away.
- Drug and alcohol abuse.
- Unusual neglect of personal appearance.
- Radical personality change.
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork.
- Frequent complaints about physical symptoms, often related to emotions, such as stomach-ache, headache, fatigue, etc.
- Loss of interest in pleasurable activities.
- Not tolerating praise or rewards.

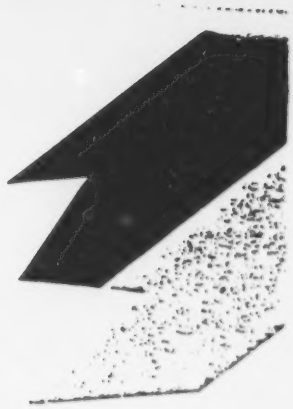
A teenager who is planning to commit suicide may also:

- Complain of being "rotten inside."
- Give verbal hints with statements such as "I won't be a problem for you much longer," "Nothing matters," "it's no use," "I won't see you again."
- Put his or her affairs in order--for example, give away favorite possessions, clean his or her room, throw things away, etc.
- Become suddenly cheerful after a period of depression.

People often feel uncomfortable talking about death. However, it can be helpful to ask the child or adolescent whether he or she is depressed or thinking about suicide. Rather than "putting thoughts into the child's head," such a question will provide assurance that somebody cares and will give the young person the chance to talk about his or her problems.

With support from family and friends and professional treatment, children and teenagers who are suicidal can be restored to a more healthy path of development.

MANAGING SUICIDAL CRISIS



What would you do if someone threatened to commit suicide? It is a fact that many of our youth are taking drastic measures to attend to their emotional needs.

Suicide is the desperate act of self-destruction for the purpose of alleviating a situation perceived as unchangeable. The Association of Suicidology reports that many troubled youth view death as an attractive alternative to coping with stress. For some, it's a way of finding peace and escape, while for others suicide becomes a statement of protest and rage, a tool of empowerment. Teachers need to successfully intervene in a sensitive, effective and planned manner so that our youth may reach their learning potential.

CHILDREN AT HIGH RISK FOR SUICIDE

- Males.
- Adoptive and foster children.
- Children with high I.Q.s.

CAUSES OF SUICIDE

- Inability to compete in school.
- Family instability (divorce, blended family, neglect and abuse or transiency).
- Death or chronic illness of a loved one or pet, or the anniversary of such an event.
- Lack of communication about feelings of unhappiness.
- Health problems, which may occur several months prior to the attempt.
- A major disappointment or humiliation (real or imagined).
- Economic insecurity.
- Parental role failure.
- Feelings of a desire for revenge against a girlfriend, boyfriend or significant other.
- A sense of not belonging to anyone (family, community or school).
- Family treatment of suicide.

Not one of these situations in and of itself produces a suicidal youngster, but rather a collection of these factors will develop a confused, angry and ambivalent youth, especially in the context of adolescent social and personality development.

SIGNS AND SYMPTOMS OF SUICIDAL YOUTH

- Extreme mood swings — violent or rebellious behavior, then sudden cheerfulness.
- Difficulty in concentrating.
- Sudden lifestyle changes.
- Withdrawal or isolation from peers and family, or from regular activities.
- Neglect of personal appearance.
- Previous suicide attempts.
- Loss of friends, such as a boyfriend, girlfriend or best friend.
- Giving away possessions, pulling affairs together, voluntarily cleaning own room or throwing things out.
- Decline in quality of schoolwork, or failing grades.
- Noticeable change in sleep habits and energy level.
- Frequent suicidal talk.
- Nightmares, enuresis, encopresis or cheating.
- Drug use (half of suicidal youngsters are involved in substance abuse shortly before their suicidal death).
- Prone to too many unexplained accidents.

In general, suicidal youth have a nagging lack of optimism, lack of hope about their future, and an enormous sense of unhappiness.

CATEGORIES OF SUICIDAL BEHAVIOR

- The pupil who makes clear statements about suicide. It may be revealed through writing assignments, drawing or indirect verbal expression.
- The pupil who makes an actual attempt that comes to the attention of one or more persons.
- The pupil who succeeds in taking his life.

For further help, see the Suicide Lethality Checklist in the appendix.

SUICIDAL THOUGHTS — WHAT TO DO

The task for each teacher in managing a suicidal crisis is to reduce the crisis state back to the student's usual state.

- Remain calm. Don't show panic. Remember the student is overwhelmed and confused as well as ambivalent.
- Get vital statistics, including the student's name, address, home phone number and parent's work number.
- Develop a quick trusting relationship. Assure the student he or she has done the right thing by making contact with you.

- Permit the student to talk. Listen! Listen! Listen! Reflect back what you hear the student saying. (Clarify, and help him or her to define the problem, if you wish.) Consider that the student is planning a trip (suicide). How does the student plan to go, and how long has he or she been planning and thinking about the trip? What events motivated the student to take this trip?
- Present options to the student. Refer the student to school district staff, a community mental health clinic or a hospital.
- Get the pupil to agree to a verbal no-suicide contract — "No matter what happens, I will not kill myself." If the student refuses or the promise is vague, contact the principal or the school district. Don't leave the student alone. Send another student for help.
- Monitor the student's behavior periodically.

WHAT NOT TO DO

- Don't ignore your suspicions or intuitions.
- Don't minimize the student's threat. Take it seriously.
- Don't worry about silences. The student needs time to think.
- Don't ever leave the student. Stay with him or her until help arrives.
- Don't send the student to the next class.
- Don't lose patience with the student.
- Don't promise confidentiality. Promise help. Promise privacy.
- Don't discuss it in the teachers' lounge or to another student.
- Don't argue with the student about whether suicide is right or wrong.

SUICIDE IN PROGRESS — WHAT TO DO PROMPTLY

- Get the student's name, address and phone number.
- Stay with the pupil. Assure him or her that emergency help is coming.
- Don't move the student. Only provide comfort.
- Mobilize another teacher or professional to inform an administrator.
- Call 911.
- Clear other students from the scene, and direct them to return to class. Clear hallways immediately.
- Note when the incident occurred, and what the pupil said and did. Stick with the facts.
- Secure any weapon, pills or suicidal notes. Record the time the drug was taken. Provide this information to the emergency medical staff or police.
- Have the administrator or designee contact the parent. Advise the parent the child is hurt and that you will call back immediately to direct the parent to the hospital to meet the child. Tell the parent to keep the telephone line clear.

A pupil is likely to use whatever means is accessible to him or her, such as a gun, rope, knife or a place from which to jump. If you see this in progress:

- Be directive. Tell the student, "Don't jump; stand there and talk with me." "Don't cut your wrist, lay the knife or razor down." "Now talk with me." "Hand me the rope. I'll listen."

- Look at the student directly. Speak in a calm, low voice tone. Buy time. Get the student to talk. Listen. Acknowledge his or her feelings — "You are really angry; you must be feeling really hurt; you must be feeling humiliated."

WHAT NOT TO DO

- Don't moralize — "You're young, you have everything to live for."
- Don't leave the student alone.
- Don't send the student to the restroom if he or she is distraught.
- Don't discuss the student's situation with colleagues.
- Do take care of yourself after the event.

MANAGING THE CRISIS

You should know the clues and causes of suicide. You need to:

- Believe it.
- Talk freely.
- Get help.

It may be helpful to keep in mind that in any crisis situation, the stress process has three parts:

PRECIPITATING STRESS	NEGATIVE FEELING	ACTION
Rejection, loss, hurt.	Depression, anger, hurt, hopelessness.	Constructive coping or destructive response.

Show concern and ask questions in a straightforward and calm manner. Your goal is to show that you are willing to discuss suicide and that you aren't appalled or disgusted by it. Secondly, you are willing to open lines of communication and are prepared to evaluate the seriousness of the problem to get care for the student.

Adapted and reprinted with permission from Crisis Intervention Handbook, Detroit Public Schools.

SUICIDAL ASSESSMENT -- CHECKLIST*

Student's Name:_____ Date:_____ Interviewer: _____

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

Does the individual have frequent suicidal thoughts? Y N

Have there been suicide attempts by the student or significant others in his or her life? Y N

Does the student have a detailed, feasible plan? Y N

Has s/he made special arrangements as giving away prized possessions? Y N

Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife? Y N

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress? Y N

Have there been major changes in recent behavior along with negative feelings and thoughts? Y N

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other to help the student survive? Y N

Does the student feel alienated? Y N

(4) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor impulse control? Y N

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and a location where it is unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a student's regular school records.

FOLLOW-THROUGH STEPS AFTER ASSESSING SUICIDAL RISK -- CHECKLIST

____(1) As part of the process of assessment, efforts will have been made to discuss the problem openly and nonjudgmentally with the student. (Keep in mind how seriously devalued a suicidal student feels. Thus, avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.) If the student has resisted talking about the matter, it is worth a further effort because the more the student shares, the better off one is in trying to engage the student in problem solving.

___(2) Explain to the student the importance of and your responsibility for breaking confidentiality in the case of suicidal risk. Explore whether the student would prefer taking the lead or at least be present during the process of informing parents and other concerned parties.

___(3) If not, be certain the student is in a supportive and understanding environment (not left alone/isolated) while you set about informing others and arranging for help.

___(4) Try to contact parents by phone to

a) inform about concern
b) gather additional information to assess risk
c) provide information about problem and available resources
d) offer help in connecting with appropriate resources

Note: if parents are uncooperative, it may be necessary to report child endangerment after taking the following steps.

____(5) If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement). Agencies will want the following information:

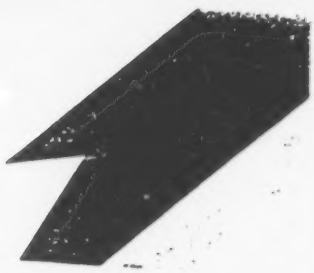
*student's name/address/birthdate/social security number
*data indicating student is a danger to self (see Suicide Assessment -- Checklist)
*stage of parent notification
*language spoken by parent/student
*health coverage plan if there is one
*where student is to be found

____(6) Follow-up with student and parents to determine what steps have been taken to minimize risk.

____(7) Document all steps taken and outcomes. Plan for aftermath intervention and support.

____(8) Report child endangerment if necessary.

SUICIDE RISK INDICATORS



The following information may be helpful when a school counselor, social worker, nurse, psychologist or qualified staff member interviews a student at-risk for suicide. Additional interview assistance can be found on page 104.

THE MORE SPECIFIC THE PLAN, THE HIGHER THE RISK

When the answer is "yes" to a question about whether a student is considering suicide, the next question needs to ask what the student has thought of doing. If the answer is "I don't know. It's just been something I've thought about," it may simply mean it has remained at the stage of an idea. If, on the other hand, the student provides a plan, the risk is higher.

WHEN?

Is the student thinking about today, tomorrow, two weeks from now? Someone who says two weeks from now usually has a specific reason for planning ahead. Ask the student what significance the future date has for them. Is it their birthday, their parent's birthday, the date when they broke up with a boy- or girlfriend, or the date when someone close to them died? The more specific the time, the higher the risk.

WHERE?

Who is more at risk, the boy who plans to hang himself in the woods or the boy who plans to hang himself in his basement? The woods is the more lethal place, because it is the least likely place where someone could happen by and prevent the attempt. When asking where, therefore, the more inaccessible the place to rescue, the higher the risk.

METHOD AVAILABILITY

When asked what the plan is, the student is likely to also relate the method. "I'm going to shoot myself or take my mother's pills" are examples. There is a need to know if the method is readily available. Is there a gun in the home? When the method is easily accessible, the risk is higher.

SUBSTANCE ABUSE

The ingestion of drugs or alcohol accompanied by thoughts of suicide is automatically a high-risk, potentially lethal situation. Substances impede impulse control and distort or intensify feelings, which in the case of the suicidal person are frequently feelings of hopelessness and helplessness.

RECENT LOSS

If there has been a recent loss of a family member due to death, divorce or separation, the risk is higher. Loss takes many forms, however, so it is important to explore a wide range of possible losses, since it only takes one loss after a series of earlier losses to push the person over the edge.

Failing to get an "A" or score high on the ACT, failure to make the team or the club, failure to be accepted in a peer group, a perceived loss of self-esteem, or the breakup of a relationship are losses, that if preceded by other losses, could be the final disappointment and reason for suicide.

If there has been a friend who has just recently killed her- or himself, and the student now being seen is feeling suicidal, he or she is at risk.

FAMILY TURMOIL OR CONFLICT

Conflict in a family, especially accompanied with physical abuse or physical fighting between child and parent, is highly correlated with suicide attempts.

PREVIOUS ATTEMPTS

If there is a history of suicide in the family, the risk tends to be greater, as that death can serve as a very strong model for what to do when there seems to be nothing else left to do. If the student has previously attempted and is once again talking about attempting suicide, the risk is greater that he or she will succeed.

TUNNEL VISION

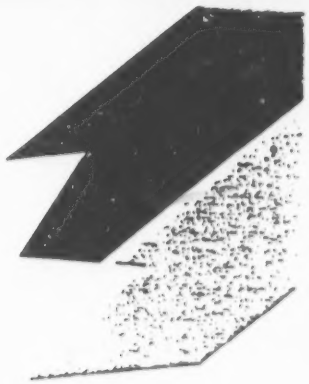
If the student is fixed on dying, the risk is higher. If, for example, the student simply has no interest in what their boy- or girlfriend might think, or if the student expresses concern, but refers to him- or herself as being a burden and it is best to end it because things will never change, the risk is greater.

REFUSAL OF HELP

If the student refuses any help, the risk is higher. The major thrust in preventing suicide is talking. If the student is closed to talking, the risk will be greater even if family and friends are supportive.

Not all these characteristics need to be present for a student to be at-risk. It is sometimes difficult to even ascertain that a youngster is thinking about suicide. It is impossible to prevent every attempt, or for that matter to always accurately assess the risk, as some children may never have thought of suicide until a crisis arises, then the thought pops into their mind and a few minutes or hours later they act.

Adapted and reprinted with permission from Patrick Murphy, Godwin Heights Public Schools.



SUICIDE LETHALITY CHECKLIST

The purpose of this screening is to determine the need for outside help and to determine a course of action. It is not to make predictions about the likelihood of suicide by a student. The specifics of a suicide plan, and the student's history, coping behavior, lifestyle, support systems and medical statistics are among the factors to be considered.

As you go through this screening process, circle the appropriate answer in one of the three columns to the right of each question. At the end of the screening more information appears on the appropriate use of this data.

	LOW	MEDIUM	HIGH
PLAN What is plan?	None	Vague	Specific
METHOD What is method?			
AVAILABILITY	Unavailable	Readily available	Present/used
WHEN	Unplanned	Vague plans	Specific plans
WHERE Location?	Unplanned	Vague	Specific
FAMILY			
Significant others	Several available	Few or none	None
Family/alcohol/ drug abuse	No		Yes
Parental functioning	Good	Adequate	Ineffective/absent
Previous suicide of significant other	No		Yes
Abuse/neglect victim	No		Yes
Family relationships	Functional	Short-term problems	Poor communications; severe problems
DAILY FUNCTIONING			
Coping skills	Good		Poor
Depression	None in past	Recent past	Chronic
Daily functioning	Normal	Losing interest in activities	No interest in activities
Withdrawal/isolation	Recent		One month or more How long?

Alcohol/drug use	No	Occasional	Regular
Self-concept	High	Average	Low
Physical health	No current medical problem	Recent health problems	Chronic eating or sleeping problems, or repeated accidents
Evidence of violence	None	Shows interest	Is violent
Recent loss or other traumatic event	No		Yes
Involvement with law	No	Pending case	Recent arrest
SUICIDE HISTORY			
Previous attempt	None	One	Multiple
Suicide threats	None		Past or present
PREVIOUS TREATMENT	None	Recent history	Current
TOTAL SCORE	LOW	MEDIUM	HIGH

There is no cutoff score. This screening provides just a general indication of a student's risk of suicide.

Low-risk students tend to express vague thoughts of hopelessness, but do not have plans to commit suicide using lethal methods. Medium-risk students usually have made direct statements about suicide, but do not have a detailed plan involving a lethal method close at hand. High-risk students most often have a detailed plan involving a lethal method. They have made final arrangements, decided that suicide is their only alternative, and have thought about exactly when and how they will commit suicide.

Intervention methods for at-risk students include immediate parental contact and referral to appropriate commmunity resources. The Crisis Resoponse Team member assigned to follow up with the student is advised to remain available for support and monitoring.

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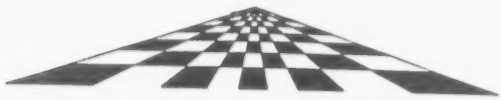
Adapted and reprinted with permission from Scott Poland, Ph.D., "Suicide Intervention in the Schools," Houston, Texas.

VI. KEEPING AFFECT AND MOOD PROBLEMS IN BROAD PERSPECTIVE

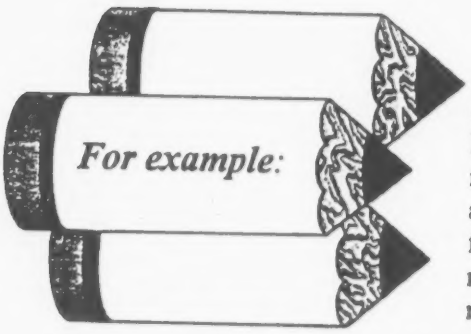


Affect and related problems are often key factors interfering with school learning and performance. As a result, considerable attention has been given to interventions to address such problems. Our reading of the research literature indicates that most methods have had only a limited impact on the learning, behavior, and emotional problems seen among school-aged youth. The reason is that for *a few,* their reading problems stem from unaccommodated disabilities, vulnerabilities, and individual developmental differences. For many, the problems stem from socioeconomic inequities that affect readiness to learn at school and the quality of schools and schooling.

If our society truly means to provide the opportunity for all students to succeed at school, fundamental changes are needed so that teachers can personalize instruction and schools can address barriers to learning. Policy makers can call for higher standards and greater accountability, improved curricula and instruction, increased discipline, reduced school violence, and on and on. None of it means much if the reforms enacted do not ultimately result in substantive changes in the classroom and throughout a school site.

Current moves to devolve and decentralize control may or may not result in the necessary transformation of schools and schooling. Such changes do provide opportunities to reorient from "district-centric" planning and resource allocation. For too long there has been a terrible disconnection between central office policy and operations and how programs and services evolve in classrooms and schools. The time is opportune for schools and classrooms to truly become the center and guiding force for all planning. That is, planning should begin with a clear image of what the classroom and school must do to teach all students effectively. Then, the focus can move to planning how a family of schools (e.g., a high school and its feeders) and the surrounding community can complement each other's efforts and achieve economies of scale. With all this clearly in perspective, central staff and state and national policy can be reoriented to the role of developing the best ways to support local efforts as defined locally.

At the same time, it is essential not to create a new mythology suggesting that every classroom and school site is unique. There are fundamentals that permeate all efforts to improve schools and schooling and that should continue to guide policy, practice, and research.



• The curriculum in every classroom must include a major emphasis on acquisition of basic knowledge and skills. However, such basics must be understood to involve more than the three Rs and cognitive development. There are many important areas of human development and functioning, and each contains "basics" that individuals may need help in acquiring. Moreover, any individual may require special accommodation in any of these areas.

• Every classroom must address student motivation as an antecedent, process, and outcome concern.

• Remedial procedures must be *added* to instructional programs for certain individuals, but only after appropriate nonremedial procedures for facilitating learning have been tried. Moreover, such procedures must be designed to build on strengths and must not supplant a continuing emphasis on promoting healthy development.

• Beyond the classroom, schools must have policy, leadership, and mechanisms for developing school-wide programs to address barriers to learning. Some of the work will need to be in partnership with other schools, some will require weaving school and community resources together. The aim is to evolve a comprehensive, multifaceted, and integrated continuum of programs and services ranging from primary prevention through early intervention to treatment of serious problems. Our work suggests that at a school this will require evolving programs to (1) enhance the ability of the classroom to enable learning, (2) provide support for the many transitions experienced by students and their families, (3) increase home involvement, (4) respond to and prevent crises, (5) offer special assistance to students and their families, and (6) expand community involvement (including volunteers).

• Leaders for education reform at all levels are confronted with the need to foster effective scale-up of promising reforms. This encompasses a major research thrust to develop efficacious demonstrations and effective models for replicating new approaches to schooling.

• Relatedly, policy makers at all levels must revisit existing policy using the lens of addressing barriers to learning with the intent of both realigning existing policy to foster cohesive practices and enacting new policies to fill critical gaps.

Clearly, there is ample direction for improving how schools address barriers to learning. The time to do so is now. Unfortunately, too many school professionals and researchers are caught up in the day-by-day pressures of their current roles and functions. Everyone is so busy "doing" that there is no time to introduce better ways. One is reminded of Winnie-The-Pooh who was always going down the stairs, bump, bump, bump, on his head behind Christopher Robin. He thinks it is the only way to go down stairs. Still, he reasons, there might be a better way if only he could stop bumping long enough to figure it out.

Related Packets from Our Center
UCLA Center for Mental Health in Schools

- **A Resource Aid Packet on Student and Psychotropic Medication: The School's Role**

  This sample packet is divided into three sections. Section 1 provides an overview perspective, guidelines, and tools related to a school's role in administering and monitoring medication, educating school staff about medication, and providing guidance for students on medication. Section 2 highlights major medications and their side effects. And Section 3 outlines resources for more information and support.

  Keywords: psychotropic medication, attention deficit hyperactivity disorder, conduct disorder, anxiety disorder, depression, bipolar disorder, Tourette's syndrome, psychoses, pervasive developmental disorders, case monitoring, case management, affective disorders, behavioral problems, children, medicine, psychiatry

- **Center Guidebook: Common Psychosocial Problems of School Aged Youth Developmental Variations, Problems, Disorders and Perspectives for Prevention and Treatment**

  This resource provides frameworks and strategies to guide schools as they encounter common psychosocial problems. It is designed as a desk reference aid. After an introductory overview of mental health in schools, Part I stresses ways to keep the environment in perspective as a cause of certain types of problems. Part II frames the full range of programs that allow a school and community to address psychosocial problems. Part III covers five of the most common "syndromes" students manifest and schools agonize over: attention problems, conduct and behavior problems, anxiety problems, affect and mood problems, social / interpersonal problems. Part IV explores ways to increase a school's capacity to prevent and ameliorate problems. part V provides additional sources of information, including agencies and organizations that can provide further information and support.

✦ A Resource Aid Packet on Responding to Crisis at a School

Provides a set of guides and handouts for use in crisis planning and as aids for training staff to respond effectively. Contains materials to guide the organization and initial training of a school-based crisis team, as well as materials for use in ongoing training and as information handouts for staff and in some cases for students and parents.

Keywords: crisis response, school-based intervention, training, crisis, resources, students, family-school interactions, staff development, education/training of school staff members, program design and implementation, coping, crisis assistance, violence, death, family violence, domestic violence, grief, sexual assault, gangs, violent behavior, sexual abuse, behavioral initiatives, suicide

✦ A Resource Aid Packet on Screening/Assessing Students: Indicators and Tools

Designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.

Keywords: screening and assessment, resources, social problems, academic problems, substance abuse, childhood depression, suicide, drugs, behavioral initiatives

✦ An Introductory Packet on Assessing to Address Barriers to Learning

Discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on the types of procedures and instruments to measure psychosocial, as well as environmental barriers to learning.

Keywords: screening and assessment, reducing barriers to learning, resources, learning resources, learning disabilities, intervention, cultural diversity, depression, childhood-depression, suicide, multi-cultural, behavioral initiatives

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For ordering information contact:
School Mental Health Project; Dept. of Psychology/UCLA; Los Angeles, CA, 90095-1563;
Phone: 310-825-3634; FAX: 310-206-8716;
http://smhp.psych.ucla.edu

To maintain a broad perspective of the reforms needed to address barriers to learning, we organize our thinking and materials around the following three categories:

Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - Collaborative Teams
  - School-community service linkages
  - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - Systemic change strategies
  - Involving stakeholders in decisions
  - Staffing patterns
  - Financing
  - Evaluation, Quality Assurance
  - Legal Issues
- Professional standards

Programs and Process Concerns

- Clustering activities into a cohesive, programmatic approach
  - Support for transitions
  - Mental health education to enhance healthy development & prevent problems
  - Parent/home involvement
  - Enhancing classrooms to reduce referrals (including prereferral interventions)
  - Use of volunteers/trainees
  - Outreach to community
  - Crisis response
  - Crisis and violence prevention (including safe schools)
- Staff capacity building & support
  - Cultural competence
  - Minimizing burnout
- Interventions for student and family assistance
  - Screening/Assessment
  - Enhancing triage & ref. processes
  - Least Intervention Needed
  - Short-term student counseling
  - Family counseling and support
  - Case monitoring/management
  - Confidentiality
  - Record keeping and reporting
  - School-based Clinics

Psychosocial Problems

- Drug/alcoh. abuse
- Depression/suicide
- Grief
- Dropout prevention
- Learning problems
- School adjustment (including newcomer acculturation)
- Pregnancy prevention/support
- Eating problems (anorexia, bulim.)
- Physical/Sexual Abuse
- Neglect
- Gangs
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Gender and sexuality
- Reactions to chronic illness

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